COMMONWEALTH OF KENTUCKY

Personnel Cabinet
Department for Employee Insurance

# K E H P

## Kentucky Employees Health Plan

# Administration Manual

This manual has been designed to assist in the proper administration of the Kentucky Employees Health Plan (KEHP). It is intended for use by insurance coordinators and agency personnel. All sample letters are available on the Department for Employee Insurance's (DEI) Web site. Insurance coordinators may download the letters from the Web site and customize for the individual agency's use. If the insurance coordinator does not have access to the Web site, please contact the DEI's Member Services Branch.

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# INTRODUCTION

## I Self-Insurance

Beginning January 1, 2006, the Kentucky Employees Health Plan (KEHP) transitioned to a self-insured arrangement statewide. This means that the Commonwealth, rather than the health insurance carriers, will assume the risk of our claims. To accomplish this, the Commonwealth pays an administrative fee to Humana, the KEHP's Third Party Administrator (TPA) to process health insurance claims and to access Humana's provider network.

## II KEHP Partners

Humana, the TPA and Express Scripts, Inc., the Pharmacy Benefits Manager (PBM) have established relationships with several business partners to assist with the administration of the KEHP and to provide specialized services to our employees. These partners have been approved by the Commonwealth of Kentucky and comply with all privacy regulations.

- **Active Health Management** partners with Humana to offer Disease Management, Case Management and Utilization Management programs to the KEHP members.

- **Ceridian COBRA Continuation Services** partners with Humana to administer COBRA continuation services for KEHP members. Ceridian uses a WebQE method for notification and enrollment of the KEHP's COBRA population. This means that each insurance coordinator will be able to enter a member's new hire and COBRA Qualifying Event information via the Internet. Once the insurance coordinator has entered the required information, Ceridian will be responsible for notification letters, enrollment, premium collection, and other related services.

- **CorpHealth, Inc**. partners with Humana to provide mental health and substance abuse services.

- **CuraScript Pharmacy** partners with Express Scripts to provide certain oral and injectable specialty medications. There are certain specialty drugs which are required to be filled through CuraScript. Members are allowed to fill the first prescription at the retail pharmacy. Express Scripts then advises the member that any future prescriptions are to be filled through CuraScript. CuraScript mails medications to the member's home, in addition to all needed supplies, at no additional cost.

- **Gordian Health Solutions** partners with Humana to offer a Personal Health Analysis (PHA) which is available on the Web site at www.myhumana.com.

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# ELIGIBILITY AND ENROLLMENT


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## I Eligible Participants

**NOTE:** For purposes of this Administration Manual, the term "employee" includes full-time employees, retirees and/or beneficiaries, classified or certified school employees and COBRA participants.

**NOTE:** Employees, retirees or COBRA participants and/or their dependents may only be covered under **one** state-sponsored plan.

### A. Full-time employees

Full-time employees of the following agencies who contribute to one of the state-sponsored retirement systems are eligible to participate:

State Agencies;
Boards of Education;
Health Departments; and
Quasi Agencies.

### B. Retirees

Retirees, **under age sixty-five (65),** who draw a monthly retirement check from any of the following retirement systems are eligible to participate according to plan guidelines:

Judicial Retirement Plan;
Legislators Retirement Plan;
Kentucky Community and Technical College System (KCTCS);
Kentucky Retirement Systems (KRS), which include:

- County Employees Retirement System (CERS);
- Kentucky Employees Retirement System (KERS);
- State Police Retirement System (SPRS).

Kentucky Teachers' Retirement System (KTRS).

KRS retirees that have returned to active employment have the option to select coverage either through KRS or through the active employer. Refer to KRS for specific information regarding this issue.

KTRS retirees that have returned to active employment must select coverage through the active employer. Refer to KTRS for specific information regarding this issue.

## C. COBRA qualified beneficiaries

## D. Dependents

Dependents who meet the following dependent eligibility requirements, are eligible for participation under the Kentucky Employees Health Plan (KEHP).

A dependent is:

- A member's spouse under an existing legal marriage;
- A member's dependent child;

Congress made changes to the definition of dependent for tax purposes, which may affect the eligibility of a member's dependents for their health insurance coverage. Congress divided dependent into a "Qualifying Child" and a "Qualifying Relative".

- For purposes of our health insurance Plan, a "Qualifying Child" is a member's child, stepchild, adopted child, foster child or grandchild (see Supporting Documentation guidelines on pages 3-12 and 3-13), who lives with the member for more than half of the taxable year, is less than 19 years of age at the end of the NEXT calendar year and will not provide over one-half of his own support during the calendar year.
  - A foster child must have been placed by an authorized agency or by judgment, decree or court order.
  - Temporary absences, such as for school, are permitted.
  - A child will remain eligible beyond the 19th birthday if he/she is a full-time student who will be less than 24 years of age at the end of the NEXT calendar year.
  - Age restrictions do not apply to a child that is permanently and totally disabled. (See next page for more details)

- For purposes of our health insurance Plan, a "Qualifying Relative" is a member's child, stepchild, adopted child, foster child or grandchild (see Supporting Documentation guidelines on pages 3-12 and 3-13), who lives with the member for more than half of the taxable year, is less than 24 years of age at the end of the NEXT calendar year and for whom the employee will provide over one-half of his support.

- For purposes of our health insurance Plan, a child who does not live with the member, but for whom the member or his/her spouse has a legal obligation under a divorce decree, court order or administrative order to provide the health care expenses of the child, remains eligible for coverage as a "Qualifying Child" or "Qualifying Relative", depending on the child's age.

Dependents may only be covered under one (1) state sponsored plan. The employee with custody shall have first option to cover the dependent children, unless both employees agree otherwise in writing.

- For purposes of our health insurance Plan, an unmarried disabled dependent may *continue* to be covered under the Plan beyond the age limit if the disability started before the limiting age and is medically certified by a physician. A disabled dependent not covered under the Plan prior to the limiting age due to having other health insurance coverage may be enrolled in the KEHP if he/she **loses** the other health insurance coverage.

  A total disability is defined as the condition that results when any medically determinable physical or mental condition prevents a dependent from engaging in substantial gainful activity and can be expected to result in death or to be of a continuous or indefinite duration. KEHP may require proof of the dependent's disability at least annually.

  If an eligible disabled dependent has not been coded as a disabled dependent (DD) on the health insurance application or form prior to reaching the limiting age, the child will be automatically dropped from the Plan at the end of the calendar year in which he/she turns 23. In order to code a child as a DD at that time, the DEI will request a physician's statement attesting to the disabled dependent's disability. The physician's statement will be submitted to the Third Party Administrator (TPA) for review and approval.

  If during Open Enrollment, a member wishes to enroll a disabled dependent that is past the limiting age, the member must show proof that the disabled dependent has experienced a loss of coverage. The request to add the disabled dependent must be made within 30 days of the Qualifying Event.

  The insurance coordinator will be notified of the TPA's determination. If approved, coverage for the disabled dependent will be processed by the DEI.

# II Employer Contribution

## A. State agencies, boards of education and health departments

In order to be eligible to receive the employer contribution, employees must meet one of the following:

- Full-time employees are eligible for the employer contribution for the following month after the initial waiting period for new hire, if during the month, they use:
  - any combination of workdays;
  - paid leave; and/or
  - Family Medical Leave (Refer to Chapter 6 for additional information on FMLA.)

- Employees that are unable to work and elect to use paid leave to qualify for the employer contribution must use those days consecutively.

- Employees returning from leave without pay (LWOP) must work at least one day in the month to qualify for the employer contribution for the following month. (refer to Chapter 6 for additional information on LWOP)

- Employees who have exhausted paid leave and FMLA shall not qualify for the employer contribution for health benefits unless they work at least one day in the previous month.

### B. Quasi governmental agencies

Insurance coordinators for quasi-governmental agencies should refer to their administrative regulations or internal policies if a discrepancy exists.

### C. Dual employment

Employees who work full-time for two (2) participating employers, and meet the eligibility requirements for both employers, are eligible for the employer contribution from each employer. However, employees are only eligible for health insurance coverage under one state-sponsored plan. Therefore, dual employees may take health insurance through one employer and waive coverage through the other employer and deposit any available employer contribution into a Health Care Flexible Spending Account.

## III Levels of Coverage

**Single** – covers the employee only.

**Parent Plus** – covers the employee and one or more eligible children.

**Couple** – covers the employee and the employee's spouse only.

**Family** – covers the employee, spouse and one or more eligible children.

## IV Cross-Reference Payment Option

Cross-reference is a payment option available to two (2) legally married participating members in the KEHP. ***A family cross-reference payment option terminates when one of the participating employees terminates employment; however, the level of coverage (family) will remain the same. The remaining eligible employee will pay for the cost of the family plan.***

The remaining employee will be allowed to select a different plan option, if requested (Commonwealth Essential, Commonwealth Enhanced, or Commonwealth Premier). As the insurance coordinator, you should explain this to any employee selecting the family cross-reference payment option.

## A. Family plan

Two (2) eligible members of the KEHP may enroll themselves and their eligible dependent children in a family plan and elect the cross-reference payment option. This means that the cross-reference employee contribution will be deducted from each member's paycheck.

## B. Cross-reference requirements

To be eligible to select the cross-reference payment option with a family plan, each of the following requirements must be met:

- the members must be legally married (husband and wife);
- the members must be eligible employees or retirees* of a group participating in the KEHP;
- the members must elect the same coverage; and
- the health insurance application must be completed, signed, and dated by the deadline by **both** members and filed with their employers' insurance coordinators.

Failure to meet any one of the above requirements will make the employees ineligible for the cross-reference payment option.

**Members of the Judicial and Legislators Retirement Plans are not eligible to choose the cross-reference payment option.*

## C. When can the cross-reference payment option be selected?

Employees may select the cross-reference payment option at the following times:

- during the Open Enrollment period;
- at the time of hire with a participating group - **the newly hired employee must elect coverage to match the existing employee/retiree's elections (the existing employee becomes the planholder);**
- at retirement – newly retired members of a participating retirement system can elect a cross-reference payment option, if applicable. **The new retiree must elect coverage to match the existing employee/retiree's elections (the existing employee becomes the planholder);** or
- during certain Qualifying Events (QE). When two (2) employees experience a QE which will allow their plans to merge into one (1) cross-reference payment option, one or both employees may change their plan option (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier) in order to start a cross-reference payment option.

**NOTE:**

If a member's spouse's employer joins the KEHP during the Plan Year, the member and their spouse WILL NOT be allowed to elect a cross-reference payment option because no Qualifying Event has occurred.

### D. Ending the cross-reference payment option

Employees will not be eligible to continue to elect the cross-reference payment option if any of the following events occur:

- termination of employment – if one of the members in a cross-reference payment option terminates employment, **the cross-reference payment option will terminate.** The employee terminating employment has not experienced a loss of coverage; therefore, a plan level change is not permitted. However, the remaining member may request an option change (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier). The terminating employee is no longer eligible to receive an employer contribution; therefore, **the remaining member will be responsible for the payment of the family premium;** or
- new retirement – newly retired members of a participating retirement system can elect to stop their cross-reference payment option. The spouse of the new retiree will be enrolled in a coverage level that corresponds to the new retiree's elections; or
- experiencing a QE that allows members to drop their spouse – changes in plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier) will be allowed; or
- experiencing a QE that allows members to drop their only dependent child – in this situation, the covered members will be assigned to two (2) single plans. Changes in plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier) will be allowed.

## V Initial Enrollment

Coverage for new employees will begin on the first day of the second calendar month following the employee's hire date. For example, if employment begins anytime in August, the employee is eligible for coverage October 1.

New employees must complete, sign, and date a new application to apply for coverage or waive their coverage within the first thirty (30) days of employment.

Employees failing to apply for coverage or waive their coverage within thirty (30) days will not have coverage and will not be allowed to enroll until the next Open Enrollment period, unless an appropriate Qualifying Event occurs. The insurance coordinator must submit a health insurance application to the DEI (waiving coverage with no FSA) in order to enter the member's information into the Group Health Insurance (GHI) system.

The GHI system counts exactly thirty (30) calendar days beginning with the day after the hire date or event date.

**NOTE TO INSURANCE COORDINATORS OF QUASI-GOVERNMENTAL AGENCIES**:
Refer to your administrative regulations or internal policies. If your probationary period for benefits eligibility is longer than the described above for state agencies, boards of education, and health departments, the employee must sign the health insurance application thirty (30) days prior to the effective date of coverage. Employees who fail to apply for coverage or waive their coverage within the deadline will not have coverage and will not be allowed to enroll until the next Open Enrollment period unless an appropriate Qualifying Event occurs. For instance, if your agency has a six (6) month

waiting period before health insurance coverage is effective and the employee is hired on January 1, the employee must sign the application prior to May 31 in order to be effective July 1.

# VI Waiving Coverage

## A. Waivers will only be accepted:

- during the annual Open Enrollment period;
- from a new employee no later than thirty (30) days from hire date or thirty (30) days prior to the effective date (for some quasi governmental agencies); or
- with an appropriate Qualifying Event.

To waive coverage, employees must complete all applicable sections of the health insurance application.

Employees who waive coverage because they have coverage under one of the following, will be allowed to enroll in an available health plan during a Special Enrollment Period, if they can provide written proof that the previous coverage terminated (see details on loss of other coverage in Chapter 3, section VI, Detailed Description of Permitted Qualifying Events):

- another employer's group health benefit plan;
- another health insurance plan;
- military insurance coverage (TRICARE);
- Medicare or Medicaid;
- COBRA (other than for non-payment); or
- state continuation.

Active employees, age 65 or older, that want to be covered by Medicare only, may waive health insurance coverage if the appropriate form is signed by the member no later than thirty (30) days after his/her Medicare eligibility date (Refer to the TEFRA Letter in Appendix A).

## B. Failure to complete an application within thirty (30) days of the date of hire or thirty (30) days prior to the effective date (as specified by your agency)

Employees who do not complete, sign and date a health insurance application within thirty (30) days of their date of hire or thirty (30) days prior to their effective date (for some quasi-governmental groups) will not have health insurance and will not be eligible to enroll until the next Open Enrollment period or until they experience a Qualifying Event that would allow them to enroll.

The insurance coordinator must submit a health insurance application to the DEI (waiving coverage with no FSA) in order to enter the member's information into the GHI system.

### C. Failure to complete an application during Open Enrollment

Open Enrollment requirements may vary during each Open Enrollment period. Therefore, the DEI will provide specific Open Enrollment guidelines to all members during each period.

## VII County Selection

Beginning in Plan Year 2006, the Commonwealth of Kentucky is self-funding the KEHP with one Third Party Administrator (TPA) statewide. Therefore, KEHP members are not required to make a county selection when enrolling in the Plan. However, the home and work counties may still be used for reporting and analytical purposes. We encourage employees and insurance coordinators to provide this information whenever available.

## VIII Open Enrollment

Open Enrollment is a period of time for employees to make plan elections for the upcoming Plan Year. Open enrollment requirements may vary during each Open Enrollment period. Therefore, the DEI will provide specific Open Enrollment guidelines to all members during each period.

After Open Enrollment elections have been made, employees may only change their elections under very specific circumstances, such as experiencing a Qualifying Event. However, the election change must be consistent with the Qualifying Event.

## IX Coverage Changes

If there is a change in family status as defined in the federal regulations, an employee must submit the appropriate documentation according to the Qualifying Event Chart in Chapter 3. If the appropriate paperwork is not signed and dated by the employee(s) within the specified timelines, the request for change will be denied.

## X Transition from Dependent to New Employee

Dependent children that are already covered as dependents in the KEHP and become employed by a participating employer, have the following options upon hire:

### A. Become a planholder

The dependent children:

- must complete, sign, and date a health insurance application as a new hire; and
- will be dropped from the parents' plan on the day prior to the effective date of their coverage as a planholder.

**NOTE:** The planholder does not need to complete a Dependent Drop Form to drop the dependent.

### B. Remain as dependents on their parents' plan

If, upon hire, covered dependents still meet the dependent eligibility requirements, the affected parties must do the following:

- the newly hired dependent children must complete a health insurance application to waive coverage; and
- the newly hired dependent children must also submit a notarized letter from their parent(s), as explained below.

    - The parents, under whom the new employee is still covered as a dependent child, must provide the DEI with a written request to keep the child enrolled in their plan. The request must be notarized and it must state that the child still meets all dependent eligibility requirements of the Plan after employment. If the required documentation is not received by the DEI with the dependent child's application to waive coverage, the DEI will automatically terminate the child's coverage as dependent and will process as a waiver.

If the child being dropped is the only dependent child in the plan, the DEI will automatically assign the parent's coverage as follows:

- a parent plus plan will be assigned to a single plan; or
- a family plan will be assigned to a couple plan.

In addition, neither the couple cross-reference payment option, nor the single Commonwealth Essential plan is available. Therefore, the following guidelines will be applied:

- a family cross-reference payment option will become two single plans;
- Commonwealth Essential plans will become Commonwealth Enhanced plans.

The DEI will notify the parent's insurance coordinator of this action.

## XI Transfers and Rehires

### A. With a break in service of less than thirty (30) days

Employees who transfer or resign from any agency or organization within the KEHP and who experience a break in service (in employment) of less than thirty (30) days, must be reinstated to their prior elections, unless they experience a Qualifying Event (all QE guidelines apply) or an Open Enrollment period has occurred. The insurance coordinator must complete either an Update Form or an application reporting the employee's transfer.

### B. With a break in service of thirty (30) days or greater

Employees who transfer or resign from any agency or organization within the KEHP and who experience a break in service (in employment) of thirty (30) days

or greater, will be allowed to make new coverage elections (except for changes to the smoking status), if the application is signed and dated within the same deadlines applicable to a new employee. In addition, the effective date of the new coverage will follow the new employee timelines.

# XII Coverage Terminations

## A. Termination of employment

Health insurance coverage for employees terminating employment will be provided through the end of the month following the month of termination. For example, if employment ends anytime in August, the employee is eligible for coverage through the end of September. Employees are subject to the following provisions:

- The employee's contribution will be deducted automatically from the employee's check. In the event there is not enough money in the last paycheck to cover the premium, agencies should collect from the individual or deduct the remainder from the payout of vacation or compensatory pay.
- Employees that terminate before their benefits take effect are not eligible for COBRA.
- The insurance coordinator will submit a Health Insurance Update Form listing the employee's termination date of employment and the termination date of coverage.
- The insurance coordinator will enter the termination information on Ceridian's WebQE for the employees to receive COBRA information.

## B. Death of employee

The employer contribution for health insurance will end the month of the employee's death. If the next month's contribution has been made, a refund must be requested.

- Health insurance coverage ends on the date of death if the employee had no dependents under the Plan.
- Health insurance coverage ends at the end of the month of death if the employee had dependents under the Plan.

At the time of death, the insurance coordinator should notify the family, in writing, of the following:

- date the last paycheck will be issued;
- contact information for the appropriate retirement system;
- name and phone number of the Plan's administrator;
- Flexible Spending Account information and phone number (if applicable); and
- any additional employee payroll deductions and company contact.

You will also need to enter the Qualifying Event on Ceridian's WebQE.
(See the COBRA Chapter for more information about Ceridian's WebQE)

### C. Loss of dependent eligibility

Dependent children and/or spouses who become ineligible for coverage under the Plan (other than for attaining the limiting age) will be terminated at the end of the month they cease to meet the dependency requirements.

Dependent children who become ineligible under the Plan due to attaining the limiting age will be terminated at the end of the calendar YEAR *prior* to attaining the limiting age. For instance, if a dependent child turns 24 in May 2007, the dependent child's coverage will terminate on December 31, 2006. Consequently, the dependent child will not be able to enroll in the Plan in 2007 or thereafter.

You may refer to the Qualifying Event chart in Chapter 3 for the termination dates resulting from Qualifying Events.

## XIII Retro Activity Related to Premiums

### A. Terminations

Any mid-year election resulting in the termination of a covered person will be effective on the date as designated under the terms of the KEHP. If the DEI receives notification of a termination more than ninety (90) days after the event causing the termination, the premium will be refunded as shown in the following table:

| Notification received in: | Count From: | Months for which Premium is to be refunded: |
|---|---|---|
| January | January 31 | January |
| February | February 28 | January and February |
| March | March 31 | January, February and March |
| April | April 30 | February, March and April |
| May | May 31 | March, April and May |
| June | June 30 | April, May and June |
| July | July 31 | May, June and July |
| August | August 31 | June, July and August |
| September | September 30 | July, August and September |
| October | October 31 | August, September and October |
| November | November 30 | September, October and November |
| December | December 31 | October, November and December |

### B. Overpayment requirements

The DEI will issue refund checks for any erroneous overpayments. Refund checks, except for those to quasi governmental agencies, will be made payable to:

- the Kentucky State Treasurer, if the overpayment is to the employer;
- the employee, if the overpayment is the employee's share; or
- separate checks for both the employee and the Kentucky State Treasurer, if there is an overpayment of both employee and employer payments.

Refund checks will be sent to the appropriate insurance coordinator or payroll officer no later than thirty (30) days from receipt of the request for refund.

Either the insurance coordinator or the payroll officer should initiate the request for such refunds. The following list, while not all-inclusive, defines when a refund may be requested:

- a check is issued in error;
- an employee terminates at the end of the month and one-half the premium is deducted and sent to the DEI;
- an employee is enrolled with the wrong option or coverage level;
- the occurrence of a Qualifying Event, since the Commonwealth is a pre-paid health plan; or
- an employee is ineligible or becomes ineligible.

***IMPORTANT:*** **Do not take premium credits from your agency account in lieu of refunds.**

Refunds will be restricted to the beginning of the current plan year to a maximum period of three (3) months or ninety (90) days, except in the event of the death of a covered person. Premium refunds will be given to the end of the coverage period due to the death of any covered person.

# GENERAL ADMINISTRATION

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| II | Fraud | | |
| III | Double Dipping | V | ID Cards |

## I Grievance Procedures

### A. Appeals to the Third Party Administrator (TPA)

Humana, the TPA for the Kentucky Employees Health Plan (KEHP), has a two-level internal appeals procedure. Appeals to the TPA include, but are not limited to: medical claims rejections, medical claims adjudication, medical prior authorization denials, medical provider networks, etc.

### B. Appeals to the Pharmacy Benefits Manager (PBM)

Express Scripts, Inc. (ESI), the PBM for the Kentucky Employees Health Plan, has a one-level internal appeals procedure. Appeals to the PBM include, but are not limited to: pharmacy prior authorizations, pharmacy step therapy, pharmacy Quantity Level Limit (QLL), pharmacy refill frequency, pharmacy provider networks, etc.

### C. Appeals to the Kentucky Office of Insurance (KOI)

The KOI will be available to provide external reviews and third party reviews after KEHP members have exhausted the TPA and/or the PBM's internal levels of appeals.

### D. Appeals to the KEHP's Grievance Committee

Employees who are dissatisfied with a decision regarding enrollment or disenrollment in the KEHP may file a grievance to the KEHP's Grievance Committee. Employees must file the grievance no later than thirty (30) calendar days from the event or notice of the decision being protested. Grievances must be filed in writing to:

Personnel Cabinet
Department for Employee Insurance
Attention: Grievance Committee
200 Fair Oaks Lane, Suite 502
Frankfort, KY 40601

A grievance must include ALL of the following items:

- name, Social Security Number and agency;
- a description of the issue(s) disputed by the member;
- a statement of the resolution requested by the member;

- all other relevant information; and
- all supporting documentation.

Grievances without all necessary information will be returned without review.

A written response will be mailed to the employee and to the agency's health insurance coordinator stating the decision of the Committee.

The Committee will not review a second request **unless** additional relevant facts are provided.

**Notes:**

- Non-covered benefits or non-covered prescriptions are not appealable to the Grievance Committee.
- The Grievance Committee will only review grievances regarding enrollment and/or eligibility.

## II Fraud

If the TPA, the PBM, and/or the KEHP believe that any fraudulent activity has occurred, they are authorized to investigate and resolve issues arising from the fraudulent activity. Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing any incorrect information or a forged or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. Any material misrepresentation may be used to reduce or deny a claim or to terminate coverage.

## III Double Dipping

Employees (or their spouse) that are eligible for and participate in the KEHP as retirees (or as the spouse or beneficiary of a retiree) and as employees (or spouses), are permitted to have only one employer contribution. They are not allowed to receive a contribution as retirees and a second contribution as employees. Specifically, KRS 18A.225 (13) addresses it as follows:

> "Any employee who is eligible for and elects to participate in the state health insurance program as a retiree, or the spouse or beneficiary of a retiree, under any one (1) of the state-sponsored retirement systems shall not be eligible to receive the state health insurance contribution toward health care coverage as a result of any other employment for which there is a public employer contribution. This does not preclude a retiree and an active employee spouse from using both contributions to the extent needed for purchase of one (1) state sponsored health insurance policy for that plan year."

Example: A hazardous-duty retiree receives a fully paid family plan from KRS. The spouse of the hazardous-duty retiree is an active employee. The spouse can elect to be covered either in the family plan or under his/her own single plan through the active employer. If the active employee elects coverage under the hazardous-duty retiree's family plan, he/she will not be allowed to waive and redirect an active employer contribution into a Flexible Spending Account.

KRS retirees that have returned to active employment have the option to select coverage either through KRS or through the active employer. Refer to KRS for specific information regarding this issue.

KTRS retirees that have returned to active employment must select coverage through the active employer. Refer to KTRS for specific information regarding this issue.

# IV Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is legislation enacted by the federal government to: ensure health insurance portability; reduce health care fraud and abuse; guarantee the integrity and confidentiality of health information; and improve the operations of the health care system.

## A. Privacy

HIPAA specifically addresses protecting the privacy of protected health information (PHI). The government has established limitations on the sharing of PHI.

PHI is medical and demographic information that is identifiable to a specific person. Examples of PHI are an individual's address, gender, Social Security Number, date of birth, diagnosis or claims history.

## B. What is DEI doing to comply with HIPAA?

Due to the need to comply with HIPAA, the DEI implemented several changes designed to protect health information used in electronic mail. These changes are applicable to all programs.

When a plan member's information is being transmitted via electronic mail there are two competing interests: (1) The plan member has an expectation that the use of PHI is limited to the minimum necessary to carry out the purpose of the communication; and (2) The employees involved in the communication have an interest in sharing the maximum amount of information permissible to expediently carry out their job function.

In addition to those concerns, electronic mail is considered a public document and is subject to open records requests. One of the DEI's concerns is that PHI transmitted via electronic mail may be inadvertently disclosed to the public through an open records request.

Based on these concerns, the DEI implemented the following procedures for transmitting member information (PHI or personally identifiable information) to carriers and coordinators via electronic mail:

- Use the word "Confidential" with the member's last name in the subject line (ex. Confidential – Smith).

This procedure is necessary to ensure that the Commonwealth Office of Technology (COT) can identify all electronic mail to and from this office containing personally identifiable information. If an open records request is made that would include any electronic mail marked *confidential*, the request will be forwarded to the DEI so that the requested electronic mail may be edited before complying.

- Use the member's last name and the last four (4) digits of the Social Security Number in the text of the electronic mail message to identify the member (ex. Smith-2390). Although the abbreviated information may cause some inefficiency in communication, it is necessary to protect the information regarding members.

- Ensure that any attachments that contain PHI are password-protected.

- Include only the information necessary to resolve the issue and any additional relevant information. Since the operations of the DEI is to procure health insurance on behalf of the KEHP; contract with TPAs for administration of the flexible spending programs; and provide the eligibility information for both, the above listed information would not be relevant to DEI's scope of operations.

- Members of the KEHP must complete and sign an Authorization for Disclosure Form to allow the DEI to disclose information pertaining to eligibility, enrollment, disenrollment and Qualifying Events regarding a member's health plan and/or flexible spending accounts to the member's spouse or dependents. Information pertaining to payment of claims and benefits covered under the health plan must be directed to the TPA. The authorization forms are on the DEI's Web site. Members may also contact the DEI's Member Services Branch to request a copy of the form.

Members will need to contact their TPA for information relating to payment of claims and which benefits are covered under the member's health plan. If the member needs to have information disclosed from the TPA to someone other than themselves, the TPA may require the member to complete its company's Authorization for Disclosure Form. The Authorization for Disclosure Form completed for the DEI to disclose PHI will not be accepted by the TPA. The member will be required to abide by the TPA's policies and procedures concerning release of the member's PHI.

## V I.D. Cards

- Employees should receive their I. D. card(s) within fourteen (14) days of receipt of enrollment information by the TPA.
- Even though the KEHP has two administrators (Humana for medical benefits and Express Scripts, Inc. for pharmacy benefits), members will only receive one I.D. card.
- For privacy reasons, the planholder's Social Security Number is not printed on the I.D. cards.
- Employees may request additional I.D. cards by calling 1-877-KYSPIRIT (1-877-597-7474).

# QUALIFYING EVENTS

| | | | |
|---|---|---|---|
| I | Section 125 Cafeteria Plan | IV | Supporting Documentation |
| II | Changes in Coverage During the Open Enrollment Period | V | General Guidelines Regarding Qualifying Events |
| III | Qualifying Event Chart | VI | Detailed Description of Permitted Qualifying Events |

## I Section 125 Cafeteria Plan

The Kentucky Employees Health Plan (KEHP) is provided through a Section 125 plan. This allows employees to pay for their health insurance premiums with pre-tax monies. Section 125 plans are federally regulated. Federal guidelines state that if employees' health insurance is offered through a Section 125 plan, they cannot make a change in their health insurance options outside of the Open Enrollment period unless they experience an appropriate Qualifying Event. Qualifying Events are also governed by federal guidelines.

## II Changes in Coverage During the Open Enrollment Period

All changes are permitted during Open Enrollment with the following exception:

- employees cannot drop dependent children for whom they are required by an administrative order to provide coverage if enforcement of the order is directed to the employer.

## III Qualifying Event Chart

This chart reflects the mid-year election changes permitted in health insurance for the entire group and the changes permitted in the Health FSA and Dependent Care FSA for Commonwealth Choice participants.

This chart describes the election changes that a cafeteria plan can permit employees to make during a period of coverage under the final cafeteria plan regulations issued in March 2000 and January 2001. Although some of the regulatory provisions are ambiguous, this chart reflects our views of permitted election changes, which are adopted for the Plan Year 2006 and each Plan Year thereafter unless amended. The only required mid-year election changes are those related to loss of eligibility (death, divorce, loss of dependency and age.)

| *Event* | *Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents* | *Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents* | *Commonwealth Choice*<br><br>*Dependent Care FSA* |
|---|---|---|---|
| **Change in Legal Marital Status** | | | |
| **Marriage** | **Add employee and/or spouse and/or dependents (1) (11) (12)**<br>*Or*<br>→→→<br>---<br>Drop employee/dependents if person becomes covered under spouse's plan (12) (10) | Start or increase election<br><br>*Or*<br>→→→<br>---<br>Decrease election if family members become covered under spouse's health plan (2) | **Start or increase election if marriage increases dependent care expenses (3)**<br>*Or*<br>---<br>Stop or decrease election if family elects dependent care assistance under spouse's plan or marriage decreases dependent care expenses (3) |
| **Divorce, legal separation, annulment** | Add employee and dependents <u>if event causes loss of coverage under spouse's plan</u>,<br>(1) (10) (11) (12)<br>*or*<br>---<br>Drop spouse; also drop family members added to former spouse's plan (12) | Start or increase election if event causes loss of coverage under spouse's health plan (2)<br>*or*<br>Stop election and redirect the state contribution to health insurance if the event causes loss of other coverage for the employee<br>*or*<br>---<br>Decrease election | Start or increase election if event increases dependent care expenses (3) or causes loss of coverage under spouse's plan<br>*or*<br>Stop or decrease election if event decreases dependent care expenses (3) |
| **Spouse's death** | Add employee and any dependent who loses coverage under spouse's plan, (1) (10) (11) (12)<br>*or*<br>---<br>Drop spouse (12) | Start or increase election if death causes loss of coverage under spouse's health plan (2)<br>*or*<br>Stop election and redirect the state contribution to health insurance if the event causes loss of other coverage for the employee<br>*or*<br>---<br>Decrease election | Start or increase election if death causes loss of coverage under spouse's plan or increases dependent care expenses (3)<br>*or*<br>---<br>Stop or decrease election if death decreases |

| *Event* | *Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents* | *Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents* | *Commonwealth Choice*<br><br>*Dependent Care FSA* |
|---|---|---|---|
| | | | dependent care expenses (3) |
| ***Change in Number of Dependents*** | | | |
| **Number of employee's eligible dependents increases by the following:**<br>**birth;**<br>**adoption (10); and**<br>**placement for adoption (10)** | Add employee and/or spouse and/or other dependents (1) (11) (12) | Start or increase election | Start or increase election if employee has greater dependent care expenses |
| **Number of employee's eligible dependents decreases (e.g., by death or because child becomes ineligible)** | Drop affected dependent (12) | Decrease election | Stop or decrease election if employee has reduced dependent care expenses |
| ***Change in Employee's Employment Status*** | | | |
| **Employee terminates employment** | Cease contributions | Cease contributions | Cease contributions |
| **Employee is rehired less than 30-days after termination of employment.** | Reinstate prior election unless intervening status change event *<br>*Employee must request status change election within 30-days of rehire. | Reinstate prior election unless intervening status change event *<br><br>**If employee did not elect COBRA during termination period, reinstatement of the prior coverage can be accomplished with one of the following methods (employee's choice):**<br><br>**Proration: Employee may elect to continue at the same monthly contribution as prior to the termination and the annual amount is reduced by the contributions missed during that period**<br><br>***or***<br><br>Reinstatement: Employee may elect to makeup the shortfall | Reinstate prior election unless intervening status change event * |

| *Event* | *Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents* | *Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents* | *Commonwealth Choice*<br><br>*Dependent Care FSA* |
|---|---|---|---|
| | | resulting from the contributions missed during the terminated period | |
| **Employee is rehired more than 30-days after termination of employment** | Make election to same extent permitted as new employee | **Make election to same extent permitted as new employee** | Make election to same extent permitted as new employee |
| **Employee commences official leave without pay** | Cease contributions | **Cease contributions** | Cease contributions |
| **Employee returns from official leave without pay** | Reinstate prior election unless intervening status change event (9) | Reinstate prior election unless intervening status change event (9)<br>**Reinstatement of the prior coverage can be accomplished with one of the following methods (employee's choice):**<br>**Proration: Employee may elect to continue at the same monthly contribution as prior to the termination and the annual amount is reduced by the contributions missed during that period**<br>***or***<br>Reinstatement: Employee may elect to makeup the shortfall resulting from the contributions missed during the terminated period | Reinstate prior election<br><br>*or*<br><br>Change election if event changes dependent care expenses (3) |
| **Employee begins unpaid FMLA leave (4) or Military Leave** | Cease contributions<br><br>*or*<br>Prepayment: Employee may increase election to prepay coverage contributions for FMLA leave period<br>*or*<br><br>Pay-as-you-go: Employee may make contributions on the same schedule as payments would have been | **Cease contributions**<br><br>***or***<br>**Prepayment: Increase election to prepay coverage during leave**<br><br>*or*<br><br>Pay-as-you-go: | Decrease election if leave causes loss of coverage or decreases dependent care expenses (3)<br>*or*<br>Cease contributions |

| *Event* | *Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents* | *Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents* | *Commonwealth Choice*<br><br>*Dependent Care FSA* |
|---|---|---|---|
| ***NOTE: Employee may choose not to participate; otherwise they must choose one payment option or another** | made otherwise<br><br>*or*<br><br>Catch-Up Option: If agreed to by both parties PRIOR to the FMLA leave, the employer may make contributions on behalf of the employee and may recoup the contributions upon the employee's return to employment | Employee may make contributions on the same schedule as payments would have been made otherwise | |
| **Employee returns from unpaid FMLA leave (4) or Military Leave** | **Reinstate prior election unless intervening status change event (9)**<br><br>NOTE: Employees returning from Military Leave are eligible for coverage immediately upon return or may delay the effective date until military coverage ends (employee's option) | **Employee must be able to reinstate prior coverage and can choose one of the following:**<br><br>**Proration: Employee may elect to continue at the same monthly contribution as prior to the FMLA and the annual amount is reduced by the contributions missed during the FMLA**<br><br>***or***<br><br>**Reinstatement: Employee may elect to makeup the shortfall resulting from the contributions missed during FMLA** | Generally same rights as employee returning from non-FMLA leave, though employee must be able to reinstate prior coverage |
| **Employee commences paid leave (assuming event does not affect eligibility for coverage)** | No change | No change | Decrease election if event decreases dependent care expenses (3) |
| **Employee returns from paid leave** | No change | No change | Increase election if event increases dependent care expenses (3) |
| **Employee changes worksite** | **No change** | No change | Decrease election if event decreases dependent care expenses (3)<br>*or*<br>Increase election if event increases dependent care |

| *Event* | *Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents* | *Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents* | *Commonwealth Choice*<br><br>*Dependent Care FSA* |
|---|---|---|---|
| | | | expenses (3)<br>(unless the care provider is a relative) |
| **Other change in employee's employment status (e.g., switch from salaried to hourly status) that causes employee to cease eligibility under plan** | **Cease contributions** | Cease contributions | Cease contributions |
| **Other change in employee's employment status (e.g., switch from hourly to salaried status) that causes employee to become eligible for coverage under plan** | Make elections as if a new employee, unless there was less than a 30-day break in employment. | Make elections as if a new employee unless there was less than 30-day break in employment | Make elections as if a new employee unless there was less than 30-day break in employment |
| ***Change in Spouse or Dependent Employment Status requirements.)*** | | ***(Dependent must continue to meet all eligibility*** | |
| **Spouse or dependent terminates employment** | **Add employee, spouse, and dependents (1) if event adversely affects eligibility for coverage under spouse's or dependent's health plan (10) (11) (12)** | Start or increase election if event adversely affects eligibility for coverage under spouse's or dependent's health plan (2) | Start or increase election if event adversely affects eligibility for coverage under spouse's dependent care assistance plan<br>*or*<br>Stop or decrease election if event decreases dependent care expenses (3) |
| **Spouse or dependent commences employment** | Drop employee, spouse, or dependent who becomes covered under spouse's or dependent's plan<br>(12) (10) | **Decrease election if family becomes covered under health plan of spouse or dependent (2)** | Start or increase election if event increases dependent care expenses (3)<br>*or*<br>Stop or decrease election if family becomes covered under spouse's dependent care assistance plan |
| **Spouse or dependent is out of work due to strike or lockout** | Add employee, spouse, and dependents (1) if event adversely affects eligibility for coverage under health plan of | Start or increase election if event adversely affects eligibility for coverage under spouse's or | Start or increase election if event adversely affects eligibility for |

| *Event* | *Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents* | *Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents* | *Commonwealth Choice*<br><br>*Dependent Care FSA* |
|---|---|---|---|
| | spouse or dependent (10) (11) (12) | dependent's health plan (2) | coverage under spouse's dependent care assistance plan *or* Stop or decrease election if event decreases dependent care expenses (3) |
| **Spouse or dependent returns to work following cessation of strike or lockout** | Drop employee, spouse, or dependent who becomes covered under spouse's or dependent's health plan (12) (10) | Decrease election if family becomes covered under health plan of spouse or dependent (2) | Start or increase election if event increases dependent care expenses (3) *or* Stop or decrease election if family becomes covered under spouse's dependent care assistance plan |
| **Spouse or dependent commences unpaid leave (if the event adversely affects eligibility for coverage under the spouse or dependent's plan)** | Add employee, spouse, and dependent (1) (10) (11) (12) | Start or increase election if event adversely affects eligibility for coverage under spouse's or dependent's health plan (2) | Start or increase election if event adversely affects eligibility for coverage under spouse's dependent care assistance plan *or* Stop or decrease election if event decreases dependent care expenses (3) |
| **Spouse or dependent returns from unpaid leave** | Drop employee, spouse, or dependent who becomes covered under spouse's or dependent's health plan (12) (10) | Decrease election if family becomes covered under spouse's or dependent's health plan (2) | Start or increase election if event increases dependent care expenses (3) *or* Stop or decrease election if family becomes covered under spouse's dependent care assistance plan |
| **Other change in spouse's or dependent's employment status that causes spouse or dependent to cease to be** | Add employee, spouse, and dependent (1) (10) (11) (12) | Start or increase election (2) | Start or increase election if event adversely affects eligibility for coverage under spouse's plan (3) |

| *Event* | *Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents* | *Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents* | *Commonwealth Choice*<br><br>*Dependent Care FSA* |
|---|---|---|---|
| **eligible for coverage under spouse's or dependent's plan (e.g., switch from salaried to hourly status)** | | | |
| **Other change in employment status that causes spouse or dependent to gain eligibility for coverage under spouse's or dependent's plan (e.g., switch from hourly to salaried status)** | Drop coverage for employee, spouse, or dependent who becomes covered under spouse's or dependent's plan (10) (12) | Decrease election if family members become covered under health plan of spouse or dependent (2) | Decrease election<br>*or*<br>**Increase election if event increases dependent care expenses (3)** |
| ***Change in Dependent Eligibility*** | | | |
| **Dependent ceases to satisfy plan eligibility requirements on account of age, marriage or any similar circumstance (support and maintenance)** | Drop coverage for dependent (12) | Decrease election | Stop or decrease election if event decreases dependent care expenses (3) |
| Unmarried dependent re-establishes plan eligibility requirement (5) under applicable plan | Add dependent who satisfies plan eligibility requirement (12) | Start or increase election | Start or increase election if event increases dependent care expenses (3) |
| ***Change in Residence*** | | | |
| Employee or spouse changes primary (6) residence and becomes ineligible for current benefit election | No Change | No Change | Make a corresponding election change if the child care provider changes |
| ***Other Events*** | | | |
| **Loss of other group health insurance coverage or health insurance coverage that entitles employee or family member** | Add employee (1) (10) (11) (12) | Start or increase election<br><br>or<br>Stop election and redirect the state contribution if the event causes loss of other | None |

| *Event* | *Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents* | *Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents* | *Commonwealth Choice Dependent Care FSA* |
|---|---|---|---|
| **to be enrolled under HIPAA Special Enrollment Rights** | *or*<br>----------<br>Add spouse and/or dependent (1) (10) (11) (12) | coverage for the employee<br>*or*<br>----------<br>Start or increase election | |
| **Judgment, decree, or administrative order relating to health coverage for child** | Add child if required under order (10) (11) (12)<br><br>*or*<br>----------<br>Drop child if other parent provides coverage under order (12) | Start or increase election if order requires employee to provide child's health coverage<br>*or*<br>----------<br>Decrease election if other parent covers child under order | None |
| **Employee, spouse, or dependent enrolled in employer's health plan becomes entitled to Medicare or Medicaid** | Make an election change that corresponds to the event (10) (12) | Decrease election | None |
| **Employee, spouse, or dependent loses entitlement to Medicare, Medicaid, KCHIP, any governmental group health insurance coverage** | Commence or increase coverage of that employee, spouse, or dependent (1) (10) (11) (12) | Start or increase election | None |
| ***Cost or Coverage Changes (8)*** | | | |
| ***Change in Cost*** | | | |
| **Benefit option has significant increase or decrease in cost** | | | Make a corresponding change (increase or decrease). Increasing the election for a day care provider raising rates mid-year is only permitted if the provider is not a relative of the employee |
| ***Change In Coverage Under Another Employer Plan*** | | | |
| **Employee's spouse makes elections during an open enrollment period** | Employee can make election change that "corresponds" with spouse's election change (10) | After Open Enrollment and before 12/31 | Employee can make election change that "corresponds" with election |

| *Event* | *Accident or Health Plan Covering Expenses of Employee, Spouse, Eligible Dependents* | *Commonwealth Choice Health FSA Covering Expenses of Employee, Spouse, Dependents* | *Commonwealth Choice*<br><br>*Dependent Care FSA* |
|---|---|---|---|
| **that differs from the open enrollment period of the employer (7)**<br><br>**----------**<br><br>**Employee makes elections during an open enrollment period of another employer that differs from the open enrollment period of the employer (7)**<br><br>**----------**<br><br>**Retiree makes elections during an open enrollment period of a state sponsored retirement system that differs from the open enrollment period of the employer** | ----------<br>Employee can make election change that corresponds with the elections made with the other employer's plan (10)<br><br>----------<br>Retiree can make an election change that corresponds with the elections made with the retirement system plan (10) | *Employee may make corresponding change (and redirect state contribution)*<br><br>After 12/31 - *None*<br>----------<br>After Open Enrollment and before 12/31<br><br>*Employee may make corresponding change (and redirect state contribution)*<br><br>After 12/31 – *None*<br>----------<br>*None* | change under the other employer plan |
| **Individual changes election for any other event that is permitted under regulation (and terms of the employer plan)** | Employee can make election change that "corresponds" with election change (10) | None | Employee can make election change that "corresponds" with election change |

## *Permitted Election Changes*

End Notes:

(1) The final regulation preamble indicates that dependents who can be added are those who were directly affected by the status change event plus other dependents (the so-called "tag-along" rule). However, the examples in the regulation only explicitly deal with situations where an employee elects family coverage and adds family members at no additional cost. It is not clear, but IRS staff members have informally stated that the "tag-along" rule applies even if the employee must increase an election to add additional dependents. Also, the preamble and examples in the regulation indicate that the "tag-along" rule applies to HIPAA events and situations where a spouse terminates employment; it is not clear what other events might be covered by the "tag-along" rule.

(2) It appears this rule does not require that a spouse's coverage include a Health FSA.

(3) By an increase or decrease in dependent care expenses, we mean that the event increases or decreases the amount of expenses that an employee can have reimbursed on a tax-free basis under Code section 129 from a dependent care assistance plan. For example, if the employee gets married and his or her spouse does not work outside the home, the spouse would be available to care for a child, and thus the employee may not be able to claim that dependent care expenses are being used to enable the employee to be gainfully employed — a condition that must be satisfied for the expense to be reimbursed on a tax-free basis under Code section 129. Conversely, the marriage can increase the amount of expenses reimbursable under the dependent care assistance plan if, for example, a new spouse or stepchild is a "qualifying individual" for whom dependent care assistance can be received. A spouse's death or divorce might lead to fewer dependent care expenses eligible for reimbursement under section 129 if, for example, the spouse was a "qualifying individual." Conversely, if the spouse was not employed outside the home, the death or divorce might require the employee to pay for a caregiver in order to remain gainfully employed, and therefore the expenses may be reimbursed on a tax-free basis under section 129.

(4) Most employees are entitled to certain rights under the Family and Medical Leave Act (FMLA), whether or not the benefits are provided through a cafeteria plan. Employees generally must receive up to 12 weeks of unpaid FMLA leave, although the employee or employer generally can choose to substitute available paid leave for unpaid leave. During FMLA leave, the employer must maintain group health coverage (including FSA coverage) on the same conditions as coverage would be provided if the employee had not taken the leave. An employee's entitlement to other benefits during FMLA leave is determined by the employer's established policy for providing such benefits when the employee is on other forms of paid or unpaid leave (as appropriate). If benefits are continued during unpaid leave, proposed IRS regulations allow benefits purchased through a cafeteria plan to be paid in several ways, including increased salary reductions before the leave to prepay benefits or using salary reductions after the leave to "catch-up" on payments. Benefits continued on paid FMLA leave are paid for in the same manner as during any paid leave. Employees can choose to drop benefits while on leave, but FMLA requires they have the right to be reinstated upon return from leave.

(5) For purposes of eligibility in this plan, a divorced dependent is not an "unmarried" dependent.

(6) Primary residence is the official residence claimed for tax purposes.

(7) Military Insurance Coverage, which does not include Veteran's Administration benefits, is considered "Another Employer Plan".

(8) "Cost or Coverage Changes under the Employer's Plan" are not included in this chart. In the event there is a mid-year change in the health plan, specific direction will be provided to the group or groups affected.

(9) An employee must request the mid-year election change within 30 days of the return to work date.

(10) Supporting documentation required.

(11) HIPAA Special Enrollment Right.

(12) Qualifying Event permits change in plan option (Essential, Enhanced, or Premier).

### Effective Dates

Effective dates for the various mid-year election changes are as follows:

A. Events increasing coverage

1. Birth, adoption, placement for adoption = date of the event;
2. Marriage, loss of other coverage, court or administrative orders for dependent(s) or foster child(ren), expiration of COBRA = 1st day 1st month from the employee's signature date.
3. Different Open Enrollment = 1st day 1st of month (match effective date of other employer's plan)

B. Events decreasing coverage

1. Death = date of the event.
    a. death of the employee with dependents = end of month in which death occurred
    b. death of employee no dependents = date of death
    c. death of dependent = date of death
2. Divorce, loss of dependent status = End of the month of loss of eligibility.
3. Gaining other health insurance coverage (Medicare/Medicaid/Tricare/etc.) = End of the month from the employee's signature date.
4. Different Open Enrollment = Last day of the month (match other employer's plan).

All Qualifying Events must be signed by the employee 30-days from the date of the Qualifying Event, except for birth, adoption, or placement for adoption when adding the newly acquired dependent only, which is 60-days. However, Qualifying Events dealing with loss of other group coverage or gaining other group coverage may be signed by the employee prior to the Qualifying Event date.

## IV Supporting Documentation

- Divorce/Legal Separation/Annulment (if dropping members from policy):
    - filed decree signed by a judge and date-stamped "filed"; or
    - filed legal separation papers signed by a judge and date-stamped "filed"; or
    - filed annulment papers signed by a judge and date-stamped "filed".

- Adoption/Placement for adoption:
    - placement papers from the Cabinet for Health and Family Services; or
    - signed and date-stamped "filed" papers from the court; or
    - letter from adoption agency on letterhead; or
    - legal document from a US court; or
    - official document translated into English and/or copy of the child's visa – if foreign adoption.

- Judgment, decree or administrative order relating to health coverage for the child (*adding a grandchild requires guardianship or custody papers*; adding a foster child requires placement papers from the Cabinet for Health and Family Services or a filed and dated court decree):
    - a filed and dated court decree; or
    - agency administrative order; or
    - National Medical Support Notice.

- Employee, spouse or dependent enrolled in employer's health plan becomes entitled to Medicare:
    - copy of Medicare card; or
    - initial eligibility letter from the Medicare office.

- Employee, spouse or dependent enrolled in employer's health plan becomes entitled to Medicaid:
    - initial eligibility letter from the Medicaid office.

- Loss of other health insurance coverage that entitles employee or dependent to be enrolled under HIPAA:
    - HIPAA certificate from prior carrier; or
    - letter from employer/previous employer, on letterhead, identifying the coverage termination date and the person(s) covered under the policy; or
    - letter from insurance company identifying the type of coverage, the reason for termination and the person(s) covered under the policy; or
    - termination letter from governmental agency under which previous coverage was held.

- Gaining other group health insurance coverage:
    - letter from employer, on letterhead, identifying the coverage begin date and the person(s) covered by the policy; or
    - copy of new health insurance I.D. card(s) for each covered person, stating the coverage begin date.

- Different Open Enrollment:
    - letter from employer, on letterhead, identifying open enrollment deadline, effective date, and persons who are being added to or dropped from the policy.

## V General Guidelines Regarding Qualifying Events

After the Open Enrollment period, employees must experience a Qualifying Event (as listed in the Qualifying Event Chart) to add or drop dependents or, under appropriate circumstances, make other permitted changes. Unless otherwise indicated in the following explanations, if there is a discrepancy between the Detailed Description of Permitted Qualifying Events below and the Qualifying Event chart as described in the Summary Plan Description (SPD), the information in the SPD prevails.

- Requests for changes due to Qualifying Events cannot be signed before the

event takes place; except for loss of other health coverage, gaining other group coverage, entitlement to Medicare and spouse's different open enrollment period. In any case, a requested change due to a Qualifying Event will not be effective prior to the event taking place. To apply this rule, consider the following:

  - If the QE date is the first of the month, the employees may pre-sign during the previous month. For example, if loss of coverage occurs on April 1, the employee may sign the application or Dependent Add Form during the month of March. The effective date of the change will be April 1.
  - If the QE date is any other day of the month, the employees may pre-sign during that month only. For example, if loss of coverage occurs on April 18, the employee may sign the application or Dependent Add Form during the month of April. The effective date of the change will be May 1.

- The Qualifying Event date is the date the event takes place and not the date the employees or dependents are notified of the event. The DEI will accept notification date only for Entitlement to CHAMPVA, TRICARE, and governmental programs such as Medicare and Medicaid.

- Forms to use:
  - Members will complete a health insurance application if they are electing new coverage, a new waiver, a new payment option, or requesting an option change based on experiencing a Qualifying Event.
  - Members will complete a Dependent Drop Form if they are electing to drop dependents due to experiencing a Qualifying Event.
  - Members will complete a Dependent Add Form if they are electing to add dependents due to experiencing a Qualifying Event.
  - Insurance coordinators will complete a Health Insurance Update Form to report an employee's demographic changes, terminations, leaves of absence, reinstatements, etc.
  - Insurance coordinators will include a Transmittal Log with all forms submitted to the Enrollment Information Branch in order to receive confirmation that the forms have been received.
  - All forms are available on the web at www.personnel.ky.gov.

- Refunds for overpayment of premiums have a time limitation. If the DEI receives notification of a change more than ninety (90) days after the event, premiums will be refunded as defined in Chapter 1 under *Retro Activity Related to Premiums*.

- For purposes of determining the thirty (30) or sixty (60) day deadline for Qualifying Events, the GHI system counts thirty (30) or sixty (60) calendar days beginning on the day after the Qualifying Event.

- The smoking status may only be updated during the Open Enrollment period. It may not be changed due to:

  - members experiencing a Qualifying Event;
  - members experiencing a break in service (employment) of 30 (thirty) days or greater; or
  - members stop smoking during the Plan Year.

# VI Detailed Description of Permitted Qualifying Events

## A. Change in legal marital status

### 1. Marriage

- **What can employees do?**

  - add themselves and/or their spouse and/or their eligible dependent children;
  - add tag-alongs;
  - cannot add themselves only;
  - drop themselves (by completing a health insurance application to waive) if they become covered under the spouse's group plan; or
  - drop their dependent children if they become covered under the spouse's group plan.
  - change their plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier).

- **Effective date**

  - if adding – first day of the month following the employee's signature on the application or Dependent Add Form.
  - if dropping – end of the month of the employee's signature on the application or Dependent Drop Form.

- **Deadline**

  Thirty (30) days from the event date.

  **Note:** The event date when adding dependents is the date of marriage. The event date to drop dependents is the date the dropped members gain other group health insurance coverage under the spouse's plan.

- **Supporting documentation needed**

  - if adding – none;
  - if dropping due to gaining other group health coverage – see *Supporting Documentation* in section IV.

### 2. Divorce, legal separation, annulment

- **What can employees do?**

  - drop dependent children if they cease to meet the eligibility requirements under the KEHP – ineligible dependents MUST be dropped*;*
  - Dependent Drop Former spouse only – the ineligible spouse MUST be dropped from the plan*;*
  - drop dependent children <u>if they are added to former</u>

spouse's group plan; or
- add themselves and/or their dependent children if the event causes loss of coverage under the former spouse's plan; including tag-alongs;
- change their plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier).

- **Effective date**

  - if adding – first day of the month following the employee's signature on the application or Dependent Add Form;
  - if dropping former spouse– end of the month of the divorce, legal separation or annulment;
  - if dropping dependent children that were added to former spouse's group plan – end of the month of the employee's signature on the Dependent Drop Form.

- **Deadline**

  Thirty (30) days from the event date. This Qualifying Event makes the former spouse ineligible to participate in the KEHP; therefore, the former spouse must be dropped from the plan at the end of the month of ineligibility.

  **Note:** The event date when enrolling themselves or adding dependents is the date of loss of coverage.

- **Supporting documentation needed**

  - if adding themselves and their dependent children if the event causes loss of other coverage - see *Supporting Documentation* in Section IV, under loss of other coverage;
  - if dropping - see *Supporting Documentation* in section IV, under divorce/legal separation/annulment.

**3. Spouse's death**

- **What can employees do?**

  - add themselves and their dependent children that have lost coverage under the spouse's plan, including tag-alongs;
  - drop spouse from plan;
  - change their plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier).

- **Effective date**

  - if adding – first day of the month following the employee's signature on the application or Dependent Add Form;
  - the spouse's coverage will end on the spouse's date of death. The new plan will be effective on the day following the date of death.

- **Deadline**

  - if adding - thirty (30) days from the date of loss of other coverage;
  - if dropping - upon notification of the spouse's death. The deceased spouse's coverage will be terminated even if the thirty (30) day deadline is not met.

- **Supporting documentation needed**

  - to add themselves and their dependent children if the event causes loss of other coverage - see *Supporting Documentation* in section IV, under loss of other coverage;
  - to drop the deceased spouse – none.

- **Other**

  Employees that experience this Qualifying Event may be eligible for a premium refund.

  - If the event date is between the 1st and the 15th of a month, the employee will be entitled to any refund for the month of death resulting from a plan level change (family to parent plus or couple to single).
  - If the event date is between the 16th and the end of a month, the employee will not be entitled to any refund resulting from a plan level change (family to parent plus or couple to single) due to the spouse's death.

## B Change in number of dependents

### 1. Birth/adoption/placement for adoption

- **What can employees do?**

  - add themselves and/or their newborn child(ren), adopted child(ren) or placed child(ren), including tag-alongs;
  - change their plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier).

  **NOTE:** To add grandchildren, members must use the Qualifying Event *judgment, decree or administrative order relating to health coverage for the child*.

- **Effective date**

  - for birth - the child's date of birth;
  - for adoption – the child's adoption date;
  - for placement - the child's placement date;
  - **FSA effective date:** the effective date of any changes to a Flexible Spending Account due to this Qualifying Event is the

first day of the month following the employee's signature date on the application or Dependent Add Form.

- **Deadline**

  - sixty (60) days from the child's date of birth, the child's adoption date or the child's placement date when adding the newly acquired child(ren) ONLY;
  - thirty (30) days from the child's date of birth, the child's adoption date or the child's placement date when adding the newly acquired child plus any other dependents (tag-alongs).

- **Supporting documentation needed**

  - for birth – none;
  - for adoption or placement for adoption – see *Supporting Documentation* in section IV, under adoption/placement for adoption.

- **Other**

  Employees that experience this Qualifying Event and whose coverage level will change due to the event (single to parent plus or couple to family), will submit premium payments as follows:

  - If the child is born, adopted or placed between the 1st and the 15th of the month, the employee will be responsible for payment of premiums for the entire month at the new coverage level.
  - If the child is born, adopted or placed between the 16th and the end of the month, the employee will not be responsible for payment of premiums for the month of birth, adoption or placement at the new coverage level.

**2. Death of a dependent child or dependent child becomes ineligible**
(ceases to meet the eligibility requirements under the KEHP)

- **What can employees do?**

  - end coverage for the deceased dependent;
  - drop the ineligible dependent – ineligible dependents MUST be dropped from the plan;
  - change their plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier).

- **Effective date**

  - coverage of the deceased dependent will end on the dependent's date of death;
  - if the dependent's death causes a plan level change (parent plus to single or family to couple), the new plan will

be effective on the day following the dependent's date of death;
- the ineligible dependent's coverage will end at the end of the month in which the dependent becomes ineligible (due to the dependent's marriage, change in primary residence, etc.);
- if the dependent became ineligible due to attaining the limiting age, the ineligible dependent's coverage will end at the end of the year in which the dependent turns 23;
- coverage for disabled dependents that are enrolled in the Plan prior to attaining the limiting age, may continue without age limitations. Refer to Chapter 1, section I, under *Eligible Participants*, for more information.

- **Deadline**

  - thirty (30) days from the dependent's date of death or from the dependent's ineligibility date;
  - upon notification of the dependent's death or ineligibility date, the dependent termination will be processed even if the thirty (30) day deadline is not met.

- **Supporting documentation needed**

  - for a deceased dependent – none;
  - for an ineligible dependent – none, in most cases; however, the DEI reserves the right to request supporting documentation. The insurance coordinator will be notified if supporting documentation is needed.

- **Other**

  Employees that experience the Qualifying Event of death of a dependent may be eligible for a premium refund, as follows:

  - If the event date is between the 1st and the 15th of a month, the employee will be entitled to any refund for the month of death resulting from a plan level change (parent plus to single or family to couple).
  - If the event date is between the 16th and the end of a month, the employee will not be entitled to any refund resulting from a plan level change (parent plus to single or family to couple) due to the dependent's death.

  Employees that experience the Qualifying Event of dependent child becomes ineligible will be entitled to a refund as determined in the *Retroactivity Related to Premium* section.

## C. Change in employee's employment status

**1. Employees terminate employment –** see *Terminations* in Chapter 1.

2. **Employees are rehired less than 30 days after termination of employment –** see *Transfers and Rehires* in Chapter 1.

3. **Employees are rehired 30 days or more after termination of employment –** see *Transfers and Rehires* in Chapter 1.

4. **Employees commence official leave without pay (LWOP) –** see *Leave Without Pay (LWOP)* in Chapter 6.

5. **Employees return from official leave without pay (LWOP) –** see *Leave Without Pay (LWOP)* in Chapter 6.

6. **Employees commence FMLA leave –** see *Family Medical Leave Act (FMLA)* in Chapter 6.

7. **Employees return from FMLA leave –** see *Family Medical Leave Act (FMLA)* in Chapter 6.

8. **Employees commence military leave –** see *Military Leave* in Chapter 6.

9. **Employees return from military leave –** see *Military Leave* in Chapter 6.

10. **Employees commence paid leave –** see *Paid Leave* in Chapter 6.

11. **Employees return from paid leave –** see *Paid Leave* in Chapter 6.

12. **Employee changes worksite –** changes are permitted only to the employee's Dependent Care FSA.

13. **Other changes in employee employment status that cause employee to cease eligibility**

    - cease contributions;
    - insurance coordinator completes a Health Insurance Update Form to report the employee termination date and the date coverage terminates.

14. **Other changes in employee employment status that cause employee to become eligible for coverage under the plan**

    - make elections as if a new employee, unless there was less than a 30 (thirty) day break in employment, in which case changes are not allowed;
    - if the break in service is 30 (thirty) days or greater, the employee must complete an application following the new employee guidelines as described in Chapter 1, section V, *Initial Enrollment*.

## D. Change in spouse or dependent employment status

1. **Spouse or dependent loses other employer-sponsored health coverage** (termination of employment, strike or lockout, commencement of unpaid

leave, loss of eligibility under the employer's plan, etc.)

- **What can employees do?**

  - add themselves, spouse and dependents if the event adversely affects eligibility for coverage under spouse's health plan (loss of employer-sponsored group health coverage);
  - add the dependent that loses eligibility under the dependent employer (other than spouse) if they meet all eligibility requirements under the KEHP;
  - add tag-alongs;
  - change their plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier).

- **Effective date**

  - first day of the month following the employee's signature date on the application or Dependent Add Form;
  - the requested change will not be effective prior to the Qualifying Event date.
  - Commonwealth Enhanced, Commonwealth Premier).

- **Deadline**

  - thirty (30) days from the Qualifying Event date. The Qualifying Event date is the date the added members lose coverage under the employer-sponsored group health plan;
  - the application or Dependent Add Form may be signed by the employee prior to the loss of coverage.
  - Commonwealth Enhanced, Commonwealth Premier).

- **Supporting documentation needed**

  See *Supporting Documentation* in this Section, under loss of other coverage.

2. **Spouse or dependent gains other employer-sponsored group health coverage** (by commencing employment, returning to work after a strike or lockout, returning from unpaid leave, gaining eligibility under the employer's plan, etc.)

   - **What can employees do?**

     - drop coverage for themselves, their spouse and dependents if they become covered under the employer-sponsored group health coverage (coverage gained must be employer-sponsored group coverage);
     - change their plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier).

- **Effective date**

  - last day of the month in which the employee signs the Dependent Drop Form;
  - the requested change will not be effective prior to the Qualifying Event date.

- **Deadline**

  - Thirty (30) days from the Qualifying Event date. The Qualifying Event date is the date the dropped members gain coverage under the spouse or dependent's employer-sponsored group health plan.
  - The application or Dependent Add Form may be signed by the employee prior to gaining coverage.

- **Supporting documentation needed**

  See *Supporting Documentation* in this Section, under gaining other group health insurance coverage.

## E. Change in dependent eligibility

**1. Dependent ceases to satisfy Plan eligibility requirements** (on account of age, marriage, support and maintenance, etc.)

See *dependent child becomes ineligible,* in this section.

**2. Unmarried dependent re-establishes Plan eligibility requirements**

- **What can employees do?**

  - add dependents that re-establish the eligibility requirements under the KEHP;
  - cannot add tag-alongs;
  - change their plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier).

- **Effective date**

  First day of the month following the employee's signature date on the Dependent Add Form or application.

- **Deadline**

  Thirty (30) days from the Qualifying Event date.

- **Supporting documentation needed**

  - the member must provide the reason the dependent is re-establishing his/her eligibility under the guidelines of the KEHP;
  - at the discretion of the DEI, the member may be requested

to provide supporting documentation.

## F. Change in residence

### 1. Employee or spouse changes primary residence

This Qualifying Event only allows a corresponding election change to the Dependent Care FSA, if the childcare provider changes.

### 2. Dependent child changes primary residence

See *dependent child becomes ineligible,* in this section.

## G. Other events

### 1. Loss of other group health insurance coverage or other health insurance coverage

The Health Insurance Portability and Accountability Act (HIPAA) was amended to provide new rights and protections for participants and beneficiaries in group health plans. HIPAA contains protections for both health coverage offered in connection with employment (group health plans) and for individual insurance policies sold by insurance companies (individual policies).

Therefore, an employee (or dependent of a covered member) who has experienced a loss of group health insurance coverage or has experienced a loss of other health insurance may join the Plan.

- **What can employees do?**
  - add themselves and/or their spouse and/or their dependents if the event adversely affects eligibility for coverage under another employer-sponsored group plan or another health plan as listed below;
  - add tag-alongs;
  - change their plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier).

- **Effective date**
  - first day of the month following the employee's signature date on the application or Dependent Add Form;
  - the requested change will not be effective prior to the Qualifying Event date.

- **Deadline**
  - thirty (30) days from the Qualifying Event date. The Qualifying Event date is the date the added members lose coverage under the health plan;
  - the application or Dependent Add Form may be signed by

the employee prior to the loss of coverage.

- **Supporting documentation needed**

  See *Supporting Documentation* in this section, under loss of other coverage.

- **Other – the following information relates to insurance that is not employer-sponsored group health coverage**

  In addition to group health coverage, the following are recognized as valid health coverage:

  - individual Health Insurance;
  - short-term, limited-duration insurance also known as "gap" insurance; and
  - student health insurance.

  In order to enroll in the KEHP, the individual must have experienced one of the following events which caused them to lose coverage from one of the health plans listed above:

  - maximum benefits level is reached;
  - insurance company cancels policy (other than for non-payment);
  - coverage was provided under COBRA and COBRA has expired;
  - coverage was non-COBRA and the coverage terminated due to loss of eligibility for coverage (legal separation, divorce, end of dependent status, death of an employee, termination of employment, reduction in hours) or employer contributions for coverage were terminated; or
  - plan no longer offers benefits for a group of individuals.

  The following events will *NOT* be recognized as loss of other coverage with special enrollment rights because there was not a change in eligibility:

  - non-payment - choosing to stop payment of a plan for any reason;
  - non-renewal - choosing to stop renewal of a plan for any reason;
  - cancellation of coverage by policy holder for policy holder;
  - cancellation of coverage by policy holder for dependent;
  - increase in cost of coverage; or
  - reduction of contributions or level of benefits.

  The following types of insurance are *NOT* considered other coverage:

  - coverage only for accident or disability income insurance;

- coverage issued as a supplement to liability insurance;
- liability insurance;
- workers compensation or similar insurance;
- automobile medical payment insurance;
- credit-only insurance;
- coverage for on-site medical clinics; or
- other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

**2. Judgment, decree or administrative order relating to health coverage for the child (including grandchildren)**

- **What can employees do?**

  - add children to an existing plan if required by a court order, placement papers from the Cabinet for Health and Family Services, or if legal guardianship has been awarded;
  - add a grandchild – only if legal guardianship or custody has been awarded;
  - add themselves if they have previously waived coverage and the order stipulates to add child to the employees' plan offered through the employer (upon receipt of an administrative order, the employer must enroll the child on the plan. The employees are responsible for premiums due); or
  - drop children if the order stipulates that coverage is to be provided by the other parent;
  - change their plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier).

- **Effective date**

  - if adding a child at the employee's request (including grandchildren), the effective date is the first day of the month following the employee's signature on the application or Dependent Add Form;
  - if adding a child and employee's consent to enroll the child is not needed (as in the case of a National Medical Support Notice directed to the employer), the effective date is the first day of the month following the date of the administrative order or notice;
  - if dropping a child upon expiration of an order, the effective date is the last day of the month in which the child ceases to meet the eligibility requirements;
  - if dropping a child upon receipt of a new order releasing the employee from providing coverage for the child, the effective date is the last day of the month in which the child ceases to meet the eligibility requirements.

- **Deadline**

- thirty (30) days from the date the order or guardianship documents are signed by a judge;
- ineligible dependents will be dropped off the plan at the end of their ineligibility date even if the thirty (30) day deadline is not met;
- upon receipt of an order directing the employer to enroll an employee's child in the plan, the enrollment will be processed even if the thirty (30) day deadline is not met.

- **Supporting documentation needed**

  See *Supporting Documentation* in this section, under judgment, decree or administrative order relating to health coverage for the child.

**3. Employee, spouse or dependent becomes entitled to Medicare or Medicaid**

- **What can employees do?**

  - drop coverage for themselves, their spouse and their dependents if they become eligible and enrolled in Medicare or Medicaid;
  - change their plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier).

- **Effective date**

  Last day of the month in which the employee signs the Dependent Drop Form.

- **Deadline**

  - thirty (30) days from the date the employee, spouse or dependent becomes entitled to and enrolls in Medicare or Medicaid;
  - the Dependent Drop Form may be signed by the employee prior to the event date; however, the requested change will not be effective prior to the Qualifying Event date.

- **Supporting documentation needed**

  See *Supporting Documentation* in this section, under employee, spouse or dependent enrolled in employer's health plan becomes entitled to Medicare or under employee, spouse or dependent enrolled in employer's health plan becomes entitled to Medicaid.

**4. Employee, spouse or dependent loses entitlement to Medicare, Medicaid, KCHIP or any governmental group health insurance coverage**

- **What can employees do?**

  - add themselves, their spouse and dependents that have lost coverage;
  - add tag-alongs;
  - change their plan options (Commonwealth Essential, Commonwealth Enhanced, Commonwealth Premier).

- **Effective date**

  Last day of the month in which the employee signs the Dependent Add Form or application.

- **Deadline**

  - thirty (30) days from the date of loss of coverage;
  - the application or Dependent Add Form may be signed by the employee prior to the event date; however, the requested change will not be effective prior to the Qualifying Event date.

- **Supporting documentation needed**

  See *Supporting Documentation* in this section, under loss of other health insurance coverage that entitles employee or dependent to be enrolled under HIPAA.

## H. Cost or coverage changes

### 1. Benefit option has significant increase or decrease in cost (change in cost)

This Qualifying Event only allows a corresponding election change to the Dependent Care FSA. See the Qualifying Event chart for specific information.

### 2. Spouse has a different open enrollment period (includes military insurance coverage, except for Veteran's Administration benefits)

- **What can employees do?**

  - add themselves, their spouse and dependents if spouse elected to drop coverage for them during his/her open enrollment period;
  - drop themselves, their spouse and dependents if spouse elected to enroll them during his/her open enrollment period.

- **Effective Date**

  The effective date to add or drop will be the same as the effective date of the spouse's Open Enrollment effective dates.

- **Deadline**

  - thirty (30) days from the Qualifying Event date;
  - the application, Dependent Add Form or Dependent Drop Form may be signed by the employee prior to the event date;
  - the event date is the last day of the spouse's Open Enrollment period.

- **Supporting Documentation Needed**

  See *Supporting Documentation* in this section, under different open enrollment.

**3. Employee/Retiree makes elections during an open enrollment period of another employer or a state sponsored retirement plan (includes military insurance coverage, except for Veteran's Administration benefits)**

- **What can employees do?**

  - add themselves, their spouse and dependents if employee/retiree elected to drop coverage for them during his/her open enrollment period;
  - drop themselves, their spouse and dependents if employee/retiree elected to enroll them during his/her open enrollment period.

- **Effective date**

  The effective date to add or drop will match the effective date of the spouse's open enrollment effective dates.

- **Deadline**

  - thirty (30) days from the Qualifying Event date;
  - the application, Dependent Add Form or Dependent Drop Form may be signed by the employee prior to the event date;
  - the event date is the last day of the spouse's open enrollment period.

- **Supporting documentation needed**

  See *Supporting Documentation* in this section, under different open enrollment.

**3. Employee's death**

- **What can be done?**

  - drop coverage for deceased planholder and covered

dependents;
- the insurance coordinator should complete a Health Insurance Update Form indicating the employee's date of death.

- **Effective date**

  - if the deceased employee was enrolled in a Single plan, the coverage ends on the date of death;
  - if the deceased employee was enrolled in a plan with dependents (parent plus, couple or family), the coverage will end at the end of the month of the employee's date of death;
  - **FSA effective date:** the effective date of termination of a Flexible Spending Account due to this Qualifying Event, is always the date of death.

- **Deadline**

  - thirty (30) days from the employee's date of death;
  - upon notification of the employee's date of death, the coverage termination will be processed even if the thirty (30) day deadline is not met.

- **Supporting documentation needed**

  None

- **Other**

  - If the employee was enrolled in a single plan and the employee's date of death is between the 1st and the 15th of the month, the employee's account will be refunded any premiums paid for the month of death.
  - If the employee was enrolled in a single plan and the employee's date of death is between the 16th and the end of the month, the employee's account will not be refunded any premiums paid for the month of death.
  - If the employee was enrolled in a parent plus, couple or family plan, coverage for the dependents will continue through the end of the month of the employee's death. Therefore, the employee's account will not be refunded any premiums paid for the month of death.

# CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)


| | | | |
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| II | Who is Eligible for COBRA Continuation Coverage | VIII | After Receiving the Election Notice: What is Next? |
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## I What is COBRA Continuation Coverage?

The Consolidated Omnibus Budget Reconciliation Act of 1986, or COBRA, provides that virtually all employers who sponsor group health plans must permit covered individuals, who lose coverage under that plan as a result of certain enumerated events, to elect to continue their coverage under the plan for a prescribed period of time on a self-pay basis. Individuals who are entitled to COBRA continuation coverage are known as Qualified Beneficiaries.

## II Who is Eligible for COBRA Continuation Coverage?

In general, qualified beneficiaries include employees, their spouses, and dependent children who are covered under the plan the day before the Qualifying Event occurs. An amendment to the COBRA regulations made by HIPAA, permits children born to, or placed for adoption with, an employee during the period of COBRA continuation coverage to be considered a qualified beneficiary.

## III Who Administers COBRA for the Kentucky Employees Health Plan (KEHP)?

Humana, the KEHP's Third Party Administrator (TPA), has partnered with Ceridian COBRA Continuation Services to administer COBRA for KEHP members. Ceridian uses a WebQE method for notification and enrollment of the KEHP's COBRA population. This means that each insurance coordinator will be able to enter a member's new hire and COBRA Qualifying Event information via the Internet. Once the insurance coordinator has entered the required information, Ceridian will be responsible for notification letters, enrollment, premium collection, etc.

## IV How are Qualified Beneficiaries Notified of their Rights?

COBRA regulations provide that a group health plan is required to provide written notice of COBRA rights to each covered employee and his or her spouse, if any, when coverage under the plan first commences. The regulations require that group health plans furnish written notice of COBRA rights no later than 90 days after their coverage begins. This written notice may be referred to as either the Initial Notice or the General Notice.

This Initial Notice or the General Notice will be mailed to employees by Ceridian COBRA Continuation Services immediately after the insurance coordinator enters the employee's new hire information or COBRA Qualifying Event information on Ceridian's WebQE.

## V What are COBRA Triggering Events?

The following are triggering events that an employee may experience:

- Termination of employment (for reasons other than the employee's gross misconduct) ; and
- Reduction in the employee's hours of employment.

The following are triggering events that an employee's spouse or dependent children may experience:

- Termination of employment (for reasons other than the employee's gross misconduct) ;
- Reduction in the employee's hours of employment;
- Death of the employee;
- Divorce or legal separation from the employee;
- The employee's entitlement to Medicare;
- The employer's commencement of a bankruptcy proceeding under Title 11 of the United States Code; and
- The child ceasing to be a covered dependent child under the terms of the Plan.

Anytime you are notified of a triggering event, you need to determine whether that event caused the member to lose group health coverage. If it does, then it is a Qualifying Event, and you will need to enter this information in Ceridian's WebQE Notification System.

## VI What is a COBRA Qualifying Event?

A COBRA Qualifying Event is one of the trigging events listed above that results in the loss of coverage for a qualified beneficiary. The COBRA regulations provide that a triggering event is a Qualifying Event only "if, under the terms of the group health plan, the event causes the covered employee, or the spouse or a dependent child of the covered employee, to lose coverage under the plan."

Therefore, when determining if a triggering event caused a loss of coverage, carefully review the facts and relevant documents. When was the loss of coverage? Examine the Qualifying Event chart to be certain that it provides a loss of coverage upon the occurrence of a particular triggering event.

## VII When a Qualifying Event Occurs: Who Must Notify Whom?

The employer cannot detect the occurrence of some Qualifying Events, because information concerning such events is uniquely within the control of the qualified beneficiary. If the event results in a loss of coverage under the group plan then the COBRA regulations require that the covered employee or other qualified beneficiary notify the insurance coordinator of the following events:

- Divorce or legal separation;
- A dependent child ceasing to qualify as a dependent under the terms of the plan;
- The occurrence of a second Qualifying Event after the qualified beneficiary becomes entitled to COBRA continuation coverage with the maximum duration of 18 or 29 months; and
- A determination by the Social Security Administration (SSA) that a covered employee or other qualified beneficiary is disabled, or a subsequent determination by the SSA that the individual is no longer disabled.

The employee or their qualified beneficiary is required to notify you no later than 60 days after the Qualifying Event. Failure to notify you in a timely manner will result in unavailability of COBRA continuation coverage for that individual.

The employer must notify the employee of some Qualifying Events. If the event results in a loss of coverage under the group health plan, then the employer must notify the covered employee and their spouse and dependent children for the following events:

- Death of the covered employee;
- Termination of employment (other than for gross misconduct);
- Reduction in the employee's hours of employment;
- The employee's entitlement to Medicare (under Parts A or B, or both); and
- The employer's bankruptcy.

When an employee experiences any of the above Qualifying Events, you must enter all necessary information in Ceridian's WebQE. Ceridian will then mail all necessary notifications and forms within the required timeframes.

## VIII How Much Will COBRA Continuation Coverage Cost?

COBRA regulations do not require employers to pay for continuation coverage. Instead, employers are expressly permitted to charge employees 100 percent of the cost of the group health coverage, plus an additional 2 percent, for a total premium of 102 percent. The COBRA rates are included in this manual (refer to Appendix O) and the Personnel Cabinet's Web site. The additional two percent covers the added cost for administering COBRA continuation coverage.

## IX What is the Length of the COBRA Continuation Coverage Period?

Listed below is the maximum period COBRA continuation coverage is available.

| **Qualifying Events that entitle you to COBRA continuation coverage** | **Length of COBRA continuation coverage** |
|---|---|
| Termination of employee's employment (except for gross misconduct) (Former employee and covered dependents) | 18 Months |
| Reduction of the employee's hours (Former employee and covered dependents) | 18 Months |
| Death of a covered employee (Spouse and covered dependents) | 36 Months |
| Divorce or legal separation from the covered employee (Spouse and covered dependents) | 36 Months |
| Employee becomes entitled to Medicare (Part A, Part B or both) (Spouse and covered dependents) | 36 Months |
| Dependent child covered under plan ceases to be an eligible dependent under the plan | 36 Months |
| Person considered to have total disability, according to the Social Security Administration | 29 Months |

# NEW EMPLOYEE ORIENTATION

| | | | |
|---|---|---|---|
| I | New Employee Orientation | III | Memorandum Regarding Notice About Special Enrollment Rights and Notice About Women's Health and Cancer Rights Act |
| II | Health Insurance Checklist | | |

**FOR A PRINTABLE VERSION OF ALL FORMS, PLEASE GO TO THE DEI'S WEBSITE AT:**

http://personnel.ky.gov/stemp/dei/06planyear/adminfo.htm

## I New Employee Orientation

This Chapter has been designed to assist insurance coordinators with the enrollment of new employees. All new employees should receive the following information:

- Health insurance handbook;
- Memorandum regarding Notice about Special Enrollment Rights and Notice about Women's Health and Cancer Rights Act (this notice is required by Federal guidelines) (refer to Appendix B); and
- Health insurance checklist (refer to Appendix C). New employees should be given this checklist for review and they should check each item as explained to them by the insurance coordinator. This checklist ensures that employees have received the required information and protects the insurance coordinator in the event of a discrepancy.

## II Health Insurance Checklist

A health insurance checklist form is included in this Administration Manual (refer to Appendix C) to ensure consistency in the explanation of Health Insurance and Flexible Spending Account benefits.

- This form has been designed to cover essential health insurance information that MUST be given to the employee during the initial benefit orientation session.

- The completed checklist, along with the appropriate copies of the health insurance application, Flexible Spending Account enrollment form, (if applicable) should be made a part of the employee's personnel file as an acknowledgement of receipt of information. A copy of all forms should be given to the employee once they have been completed.

- If your organization is already using a benefit orientation form, make sure you incorporate all topics included on this checklist.

- On the last page of the health insurance checklist, the employee must respond to the question regarding previous employment within the last thirty (30) days with another agency participating in the Kentucky Employees Health Plan (KEHP).

- If the employee's break in service is thirty (30) days or greater, the employee may make new elections.

- If the employee's break in service is less than thirty (30) days, the employee may not change his/her previous elections unless he/she experiences a Qualifying Event giving rise to a permitted mid-year election change.

**NOTE:** The DEI is not attempting to alter your agency's policies pertaining to effective dates and payroll issues. You may consider an employee to be a "new employee" instead of a "transferring employee", but the employee will not be permitted to make election changes without a thirty (30) day break in service.

## III Memorandum regarding Notice about Special Enrollment Rights and Notice about Women's Health and Cancer Rights Act

Federal law requires that every employee must receive notification of the Notice of Special Enrollment Rights and Notice about Women's Health and Cancer Rights Act. A copy of this notice is provided for your assistance (refer to Appendix B).

# LEAVE

| | | | |
|---|---|---|---|
| I | Leave Without Pay (LWOP) | III | Paid Leave |
| II | Family Medical Leave Act (FMLA) | IV | Military Leave |

## I Leave Without Pay (LWOP)

### A. Starting LWOP

If employees are on leave without pay and they receive pay during the month the leave starts, they will be eligible for the employer contribution for health insurance for the following month. However, if the pay the employee receives is not sufficient to cover the employee's portion of the premium, they must submit a check for the amount due.

If employees are on leave without pay and they do not receive pay during a month, they will not be eligible for the employer contribution for health insurance for the following month.

Any portion of a premium due by the employee must be submitted to the insurance coordinator by the 20th of the month. The check must be payable to the Kentucky State Treasurer. The insurance coordinator will forward the payment to the Financial Management Branch (FMB).

Employees that lose coverage due to starting LWOP must be entered into Ceridian's WebQE system to receive COBRA information. Note that employees on a cross-reference payment option do not lose coverage upon starting LWOP; therefore, they are not eligible to receive COBRA information. (see section below)

**NOTE:** If the employee fails to submit appropriate premium payments due within the specified deadline, the health insurance carrier may cancel the ENTIRE POLICY. If this occurs, the insurance coordinator should request a refund of any employer contribution amount paid.

**NOTE:** When employees are granted LWOP, the insurance coordinator should send the "Guidelines for Benefits While on Approved LWOP" memo (refer to Appendix D).

### B. LWOP and cross-reference

If the employee has been on LWOP for thirty (30) days or more, the insurance coordinator must submit a Health Insurance Update Form to the DEI providing the employee's LWOP begin date and the health insurance coverage termination date.

If the LWOP employee has selected the cross-reference payment option, the cross-reference payment option must be broken. The DEI will notify the spouse's insurance coordinator that one of the cross-reference employees is on LWOP and the remaining employee will be changed to a family (non-cross-reference) plan.

The remaining employee will be responsible for payment of the total employee contribution for the family plan.

The insurance coordinator does not notify the COBRA Administrator that the employee has started a LWOP because he/she has not lost health coverage under the Plan.

## C. During LWOP

While employees are on LWOP, the following could occur:

### 1. There is an Open Enrollment period

Employees that are on LWOP during the Open Enrollment period will not receive an Open Enrollment packet.

Employees that elected COBRA will receive Open Enrollment packets from their COBRA administrator.

Upon returning to work, the employee is entitled to receive the Open Enrollment information from the insurance coordinator. Employees will have thirty (30) days from the date they return to work to apply for their Open Enrollment selections.

### 2. The employees experience a Qualifying Event

Employees on LWOP that experience a Qualifying Event must follow the same status change rules. They must request the mid-year election change within thirty (30) days from the return to work date.

The same rules as defined in the Returning from LWOP section will be applied to determine the effective date of coverage.

## D. Returning from LWOP

### 1. Eligibility for employer contribution

Any employee who returns to work after being on LWOP must work at least one day in the month they return to be eligible to receive the employer contribution for health insurance for the following month.

If the employee does not work one day or more in the month they return, the first day of the second month rule applies.

**2. Eligibility for coverage changes**

Employees who return to work after being on LWOP will not be eligible to make any changes to their health insurance coverage unless:

- They have experienced a Qualifying Event and they apply for an appropriate change no later than thirty (30) days from their return to work date.
- They return in a new Plan Year and they were on LWOP during the Open Enrollment Period. Employees must apply for a coverage change no later than thirty (30) days after their return.

The insurance coordinator must provide the necessary applications upon return.

# II Family Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide up to twelve (12) weeks of job-protected leave for certain family and medical reasons. Employees are eligible for FMLA leave if they have completed twelve (12) months of service and worked or been on paid leave at least 1,250 hours in the twelve (12) months preceding the first day of FMLA leave. This leave is available annually.

The employee may choose to use paid (annual, sick or compensatory) leave concurrently with FMLA leave. [101 KAR 2:102] The employee may choose to use unpaid leave during the FMLA leave. The employee may choose to reserve ten (10) days of accumulated sick leave prior to being placed on FMLA leave.

**NOTE:** When the employee is granted FMLA leave, the insurance coordinator should send the Guidelines for Benefits While on Approved Family Leave memo (Appendix E).

## A. Starting FMLA leave

- FMLA leave is not a Qualifying Event to change health insurance elections.
- When employees begin FMLA leave, the employer contribution for health insurance must continue through the leave period.
- Employees are responsible for the employee's share of the health insurance premiums. Employees may choose to:
  - Cease contributions (terminates entire policy);
  - Prepay the coverage contributions for the FMLA leave period;
  - Choose the pay-as-you-go method. If employees choose this method of payment:
    - The employee's contribution is due at the same time the contribution would be due if made by payroll deduction;
    - If employees fail to pay timely, they will be granted a thirty (30) day grace period;
    - If employees fail to pay the required amount by the end of the thirty (30) day grace period, the policy will be

automatically terminated back to the last date through which premium was paid; or
  - Choose the catch-up option, which should be agreed to by both parties **PRIOR** to the FMLA leave.
- The insurance coordinator is to collect the premium check (payable to the Kentucky State Treasurer) and forward it to the FMB. The insurance coordinator is to collect and process all premium checks while the employee is on FMLA leave.

## B. During FMLA

While employees are on FMLA, the following could occur:

### 1. There is an Open Enrollment Period

Employees that are on FMLA during Open Enrollment, will receive an Open Enrollment packet from the insurance coordinator.

Employees that choose to cease contributions are not eligible for health insurance under the Kentucky Employees Health Plan (KEHP) until they return to work.

### 2. Employee experiences a Qualifying Event

Employees on FMLA that experience a Qualifying Event will have thirty (30) days from their return to work date to request a status change.

## C. Returning from FMLA leave

- Employees returning from FMLA leave must be reinstated to the prior elections unless there has been an intervening status change, in which case, the employees will have thirty (30) days from their return to work date to request a status change.
- If the employee chose to suspend health insurance coverage during the FMLA leave, the employee may be reinstated to the prior elections on the date he/she returns to active status.
- If the employee is reinstated between the 1st and the 15th of a month, the employee will be responsible for payment of premiums for the entire month at the new coverage level, if applicable.
- If the employee is reinstated between the 16th and the end of a month, the employee will not be responsible for payment of premiums for the month of reinstatement at the new coverage level, if applicable.
- If the employee had coverage cancelled due to non-payment of premiums, the employee is to be reinstated to the prior elections upon payment of all past-due premiums.
- If the employee chose suspension of coverage or fails to pay past-due premiums, the agency is to request a refund of the employer contribution for the applicable months.

### D. Not returning from FMLA leave

When an employee has exhausted FMLA leave, but does not return to work (begins LWOP), the insurance coordinator must notify the employee of their COBRA rights (if eligible), regardless of the employee's insurance status during the FMLA leave.

For purposes of COBRA, the date of this COBRA Qualifying Event is the date the FMLA leave ends. The employee is eligible for eighteen (18) months of COBRA coverage.

## III Paid Leave

An employee who has worked or been on paid leave (annual, sick or compensatory time) for at least one day during a month will be eligible for the state contribution for health benefits for the following month. Paid leave must be used consecutively.

## IV Military Leave

Employees called to active military duty are eligible for health benefits through the United States government. The employee's dependents may also be eligible for military health insurance.

### A. Starting military leave

Employees may stop their health insurance coverage on the last day of the month in which they are activated with the armed services.

Employees may elect to maintain their current level of health insurance coverage as well as maintain military health care coverage.

NOTE: Refer to the Qualifying Event chart regarding Flexible Spending Accounts during military leave (state agencies only).

**If an employee has single coverage through the KEHP and is using paid leave or has not been removed from the payroll via formal action:**

- Employees may stop their health insurance coverage on the last day of the month in which they are activated with the armed services. This option will allow employees to start their health insurance coverage immediately upon return to public employment. This stop and start process will in no way negatively impact employees with regard to pre-existing conditions.

- If employees elect to maintain their current level of health insurance coverage, as well as maintain military health care coverage, employees must insure that the applicable premiums are available via payroll deduction or are received by their insurance coordinator no later than the 20th day of the month preceding the coverage month.

**If an employee has coverage for dependents through the KEHP:**

- an employee may elect to maintain their current level of health insurance coverage and insure that the applicable premiums are available via payroll deduction or are received by their insurance coordinator no later than the 20th day of the month preceding the coverage month.

- Employees may stop their health insurance coverage on the last day of the month in which they are activated with the armed services. This option will allow employees to start their health insurance upon return to public employment. This stop and start process will in no way negatively impact employees with regard to pre-existing conditions.

An employee called to active duty must elect one of the preceding options for their health insurance during the time they are activated. The only option that may be affected by the minimum or maximum length of activation is dependent coverage and the employee is responsible for that verification. All premiums due upon return from active duty will be determined by the date of return to active employment.

## B. During military leave

If employees elect to maintain their health insurance while on leave, they must ensure that the applicable premiums are available via payroll deduction or are received by their insurance coordinator no later than the 20th day of the month preceding the coverage month.

## C. Returning from military leave

Employees returning from military leave will have all benefits (health insurance and Flexible Spending Accounts) reinstated upon their return, effective the date they return, (first day of the second month rule does not apply) without any waiting period for pre-existing conditions.

**Note:** Employees returning from military leave may delay the effective date until military coverage ends (at the employee's option). Employees electing this option will have to present supporting documentation of the military coverage end date.

An employee returning between the first (1st) and the fifteenth (15th) of the month will need to pay the employee portion (family, couple, parent plus or single, if applicable) of the insurance premium for the month of return. An employee returning on the sixteenth (16th) of the month or later will be exempt from paying the premium for the month of return. In both cases, the employee will pay the employee share of the premium for subsequent months.

# PREMIUM BILLING AND RECONCILIATION

| | | | |
|---|---|---|---|
| I | Overview | III | Detailed Description of the Billing Statements |
| II | Health Insurance Billing Statements | IV | Other Payment Information |

## I Overview

The DEI has implemented a Premium Billing and Reconciliation (PB&R) system to facilitate the reconciliation and management of health insurance enrollment data and premiums. By managing all premiums, the PB&R system supports the Commonwealth's transition to the self-funded insurance model.

In order to manage the overall functioning of the system, the Personnel Cabinet, through the DEI, established the Financial Management Branch (FMB). The FMB is responsible for overseeing the following areas:

- Creation and distribution of health insurance bills;
- Reconciliation of health insurance coverage with all agencies and administrators;
- Posting and balancing of all premium payments and adjustments; and
- Reporting and resolution of discrepancies.

## II Health Insurance Billing Statements

### A. State government agencies

State government agencies do not receive a bill statement. The FMB receives a file extract from the state payroll system (UPPS). Health insurance premiums and administration fees are posted into the PB&R system automatically from this file.

Once the file extract has been loaded into the PB&R system, the FMB reviews the results and notifies each state agency's insurance coordinator regarding premium discrepancies.

### B. Boards of education

- **Employee portion of the health insurance premiums**

  Boards of education receive monthly bill statements for the employee portion of the health insurance premiums only.

  The insurance coordinators are responsible for carefully reviewing the bill statement and notifying the FMB of any changes needed that are not reflected on the bill (such as terminations, transfers, qualifying event changes, etc.) The insurance coordinators may accomplish this by making annotations on the bill statement and returning their changes to the FMB or by mailing a copy of the MUNIS health insurance remittance that they submit to the Kentucky Department of Education (KDE).

*It is important to note that the premiums received MUST match the monthly MUNIS health insurance remittances that are transmitted to KDE.*

- **Employer portion of the health insurance premiums**

  KDE pays the employer portion of the health insurance premiums and the administration fees.

### C. Health departments and quasi governmental agencies

Health departments and quasi governmental agencies receive a monthly bill statement from the FMB.

## III Detailed Description of the Billing Statements

### A. Boards of education (or MUNIS bills)

- Section 1 includes the current billing period, company name, address, company contact name and phone number.
- Section 2 includes the Social Security Number and name of each employee, plan option, coverage level and premium due for the employee portion of the health insurance.
- Section 3 includes the total amount due for the specific board.

### B. Health departments

- Section 1 includes the current billing period, company name, address, company contact name and phone number.
- Section 2 includes the Social Security Number and name of each employee, plan option, coverage level and premium due in the employer contributions column.
- Section 3 includes the total amount due for health insurance premiums and the administration fee head count for the specific health department.

  Note that each health department billing statement will not include an administration fee total. A separate billing for all health departments' administration fees is generated and mailed to a central office for payment.

### C. Quasi governmental agencies

- Section 1 includes the current billing period, company name, address, company contact name and phone number.
- Section 2 includes the Social Security Number and name of each employee, plan option, coverage level and premium due in the employer contributions column. The beginning of this section also includes the company credit amount. This is a cumulative total of any over or under payments that cannot be assigned to specific planholders.
- Section 3 includes the total amount due from the specific quasi governmental agency including the administration fee.

# IV Other Payment Information

## A. When will I get the bill statement?

Bill statements will arrive on or about the 20th of each month.

## B. To whom do I make the check(s) payable?

- All payments must be payable to the Kentucky State Treasurer.
- One payment can be submitted for both health insurance premiums and administration fees.
- The administration fees for health departments and school boards are paid by a central location; therefore, they are not included on the bill statement.

## C. Where do I mail the payment(s)?

- **Regular mailing address:**

  FINANCIAL MANAGEMENT BRANCH
  5755 RELIABLE PARKWAY
  CHICAGO, IL 60686

- **Overnight mailing address (via FedEx, DHL, or other private courier):**

  FINANCIAL MANAGEMENT BRANCH
  ATTN: LOCKBOX 5755
  5635 S. ARCHER AVENUE
  CHICAGO, IL 60638-1656

- **State government agencies (UPPS) – mail other personal checks from employees (FMLA, etc.) to:**

  PERSONNEL CABINET
  FINANCIAL MANAGEMENT BRANCH
  200 FAIR OAKS, SUITE 502
  FRANKFORT, KY 40601

## D. Who do I contact if I have questions?

Contact the Financial Management Branch staff at (502) 564-9097.

# REPORTS

I TEFRA – For Active State Employees Age Sixty-five (65) and Older
II GHI Automatic Emails
III Pended Records
IV Ineligible Dependents (Age 24)
V Web Reporting

Throughout the year, the Department for Employee Insurance (DEI) will generate reports to the insurance coordinators. These reports are developed within the Group Health Insurance (GHI) database and are provided to update insurance coordinators on applications processed through this database system. A description of each report and detailed information regarding what you are to do with each report are provided below.

## I TEFRA - For Active State Employees Age Sixty-five (65) and Older

Every month, the Personnel Cabinet's Payroll Branch generates a report of all active state employees who will turn age sixty-five (65) in the next three (3) months. The DEI's Member Services Branch will distribute this report to appropriate insurance coordinators. The TEFRA letter in Appendix A should be mailed to the employees on that list. The letter details how TEFRA affects the employees and what their options are at age sixty-five (65).

## II GHI Automatic Emails

The GHI system automatically generates an email notification to the insurance coordinator when an action is taken on a member's record. Actions such as accepts, terminations or pends will generate an email to the insurance coordinator on record. If you have submitted applications or change requests to the Enrollment Information Branch (EIB) and have not received automatic emails within a reasonable period of time, notify the EIB immediately.

## III Pended Records

This report is generated weekly and is mailed to each agency's health insurance coordinator. If an employee's application has been pended for any reason, you will receive a report listing the employee's Social Security Number, name, middle initial, the date it was pended and a note written by the EIB processor providing details about the pend action. The report also contains a message indicating the length of time the record has been in pended status and the action that will be taken if the issue is not resolved within the deadline. Pended records must be resolved within sixty (60) days of the original pend date. Records in pended status for a period greater than sixty (60) days will be rejected. This will be done by the EIB and documentation received after the deadline will not be accepted. If an application has been rejected, you will be notified in writing by the EIB.

The deadlines for Qualifying Events do not change because of a pend action. Most Qualifying Events must be signed within thirty (30) days after the event date. If a

Dependent Add Form or a Dependent Drop Form has been signed within the deadlines, but it has been pended for supporting documentation or other reason, the member will have up to sixty (60) days from the original pend date to submit the proper documentation or information requested.

## IV Ineligible Dependents (Age 24)

This report is generated in December of each year. It includes all dependents that will turn twenty-four (24) during the following calendar year. These dependents will be automatically terminated from the KEHP effective December 31. The DEI will also make changes to the employees' health insurance level based on the number of dependents remaining on the plan. The ineligible dependents are eligible to receive a COBRA notification. The notification will be mailed out by Ceridian, the Commonwealth's COBRA administrator.

If an employee has other eligible children covered under the plan, coverage will remain the same. If the child to be dropped is the only dependent child on the employee's plan, the planholder will be assigned a plan as follows:

- a parent plus plan will be assigned to a single plan;
- a family plan will be assigned to a couple plan;
- a family paying by cross-reference will be assigned to two single plans.

## V Web Reporting

You may log on to the Web site *Your KEHP Online Access* at www.openenroll.ky.gov to access your employees' records and to generate varied reports pertinent to your agency. The reports provided by the online system contain information regarding your employees' status in the GHI system (active, pended terminated, unedited or waived). It will also give you the ability to print a complete listing of your agency's employees, including their plan selection, plan cost, and Flexible Spending Account information, if applicable.

# COMMONWEALTH CHOICE FLEXIBLE SPENDING ACCOUNTS


| | | | |
|---|---|---|---|
| I | Eligibility Requirements | V | Types of Leave and FSA |
| II | UPPS Guidelines for Commonwealth Choice Deductions | VI | HIPAA |
| III | Payroll Processing | VII | Commonwealth Choice Contacts |
| IV | Contribution Amounts | | |


The Commonwealth Choice Flexible Spending Account (FSA) program allows participating Commonwealth of Kentucky employees to pay for eligible dependent care expenses and eligible health care expenses with pre-tax dollars.

Eligible employees who wish to participate in either or both the Health Care Flexible Spending Account and the Dependent Care Account must complete a new enrollment form each year during the Open Enrollment Period.

*Enrollment is NOT automatic*.

## I Eligibility Requirements

An active state government employee who is eligible for state-sponsored health insurance coverage may enroll in one or both of the Health Care and Dependent Care Spending Accounts during Open Enrollment or as a result of an applicable Qualifying Event. (Refer to the Qualifying Event chart for applicable events that would allow enrollment into the Flexible Spending Account program)

An employee may enroll in the Commonwealth Choice FSA program within thirty (30) days of his employment date or thirty (30) days of his eligibility for benefits date. The effective date will be the first day of the second month from date of hire (i.e. employee hire date is February 25, employee's effective date would be April 1). Indicate the effective date on the enrollment application and adjust the number of pay periods accordingly by using the chart in the following section.

Note that if an active state employee is a covered spouse on a hazardous duty retiree's plan, the active employee will not be eligible to put the state contribution into a Health Care FSA. For more information, refer to Chapter 2, section III, Double Dipping)

# II UPPS Guidelines for Commonwealth Choice Deductions

| Hire Date | Effective Date | # of Pay Periods Remaining in PY | First Pay Period Deductions Will be Made |
|---|---|---|---|
| November | January | 24 | 01/15 – 01/31 |
| December | February | 22 | 02/15 – 02/28 |
| January | March | 20 | 03/15 – 03/31 |
| February | April | 18 | 04/15 – 04/30 |
| March | May | 16 | 05/15 – 05/31 |
| April | June | 14 | 06/15 – 06/30 |
| May | July | 12 | 07/15 – 07/31 |
| June | August | 10 | 08/15 – 08/31 |
| July | September | 8 | 09/15 – 09/30 |
| August | October | 6 | 10/15 – 10/31 |
| September | November | 4 | 11/15 – 11/30 |
| October | December | 2 | 12/15 – 12/31 |

An employee, who previously worked for state government and had less than a thirty (30) day break in service, and returns to employment, will have the same elections prior to their break in service, unless there is an intervening status change that may result in new elections.

An employee who previously worked for state government and had a break in service of thirty (30) days or greater, and returns to employment, should be treated as a new employee.

An employee, who signs up for Commonwealth Choice during Open Enrollment **and terminates employment before coverage is effective on January 1st,** will not be offered COBRA coverage under the Flexible Spending Account for the upcoming plan year; however, he/she will be offered COBRA coverage for the prior year in which the employee terminated. If the employee returns to work after the plan year begins with less than a thirty (30) day break, he will have the same elections that he had chosen during his open enrollment period. An employee with a break in service of thirty (30) days or greater will be eligible to enroll as a new employee, with an effective date of the first day of the second month after the date of employment.

# III Payroll Processing

## A. Open Enrollment

Payroll deductions will be downloaded from the DEI's database. Insurance coordinators do not set up deductions during the Open Enrollment period unless instructed by the DEI. The DEI will send Open Enrollment information electronically to the Commonwealth Choice administrator.

### B. Initial enrollment (new hire) and Special Enrollment (Change in Status/Qualifying Events)

For information on enrollment outside Open Enrollment (i.e. new hires and Change in Status), contact your payroll officer or the DEI. Payroll deductions for initial enrollment will be set up by the DEI and payroll deductions for Special Enrollment/Qualifying Events must be set up by the insurance coordinator.

## IV Contribution Amounts

The combined contribution amount from the employer and the employee, per pay period, for the Health Care FSA is $5.00 minimum and $120 maximum.

The maximum yearly contribution amount for Dependent Care depends on your tax filing status as listed below:

- married filing separately → $2,500
- single and head of household → $5,000
- married and filing jointly → $5,000

Employees may qualify for the monthly employer contribution amount of $234 from January 1, 2006 to June 30, 2006 or $200 from July 1, 2006 to December 31, 2006, if the employee waives health insurance coverage with the Kentucky Employees Health Plan (KEHP).

Employer contributions cannot be directed into the Dependent Care Account.

## V Types of Leave and FSA

### A. Leave without Pay (LWOP)

#### 1. Break in service of less than thirty (30) days

Employees on LWOP that do not have pay during a pay period, will not be eligible for the employer contribution for Health Care FSA for that pay period. It will be the employees' responsibility to pay the combined contribution (employer/employee) for that pay period.

Employees should submit checks made payable to the Kentucky State Treasurer by the 30th of the month to:

Personnel Cabinet
Department for Employee Insurance
Flexible Spending Account Team
200 Fair Oaks Lane
5th Floor, Suite 502
Frankfort, Kentucky 40601

**Note:** If employees fail to submit a check by the due date, the total combined contribution (employee/employer) should be deducted from the first paycheck they receive once they return from LWOP. If the employees' contribution is an amount greater than anticipated, consult with the employees to determine the preferred method of payment to make current.

**2. Break in service of thirty (30) days or greater**

If an employee is on leave without pay for thirty (30) or more working days, the insurance coordinator should do the following:

- Submit a Health Insurance Update Form to the DEI providing the employee's LWOP beginning date and the FSA termination date (term date for FSA is the same as the LWOP beginning date).
- Notify the employee about COBRA rights.

**3. Returning From LWOP**

Employees returning from LWOP will be reinstated to the same elections prior to LWOP unless they experience a Qualifying Event and request a change within the required time limit for the event; they return in a new plan year; or they return after the open enrollment period and apply for a coverage change no later than thirty (30) days after the return date.

Reinstatement of an employee's prior elections can be accomplished with one of the following methods (employee's choice):

- Proration: employee may elect to continue at the same monthly contribution amount prior to the LWOP termination date and the annual amount is reduced by the contributions missed; or
- Reinstatement: employee may elect to make-up the missed contributions.

**4. Open Enrollment occurs while on LWOP**

If an employee is on LWOP during Open Enrollment, the insurance coordinator does not need to send an open enrollment packet. The packet is to be given upon the employee's return from LWOP.

If the employee did not elect COBRA, he/she is not eligible for the health care flexible spending account through the KEHP until he returns to work.

If the employee elected COBRA, the Commonwealth Choice COBRA administrator will send Open Enrollment information to the employee.

**5. Qualifying Events during LWOP**

If an employee on LWOP experiences a Qualifying Event, the same status change rules apply. However, the employee may request the mid-year election change within thirty (30) days of the return to work date.

**NOTE**: An employee is not eligible to file for reimbursement of Dependent Care expenses incurred while on LWOP.

**6. Eligibility for employer contribution for health care FSA**

An employee who returns to work after being on LWOP must work at least one day in the month he returns to be eligible to receive the employer contribution for the health care FSA in the following month.

## B. Family Medical Leave Act (FMLA)

When the employee is granted FMLA leave, the insurance coordinator should send the *Guidelines for Benefits while on Approved Family Leave* letter in appendix E.

**1. Beginning FMLA leave**

FMLA leave is not a Qualifying Event to make any changes to the health care FSA.

When an employee begins FMLA leave, the employer contribution for the health care FSA is to continue through the leave period.

The employee is responsible for the employee's share (if any) of the medical flexible spending account. The employee may choose to:

- Cease contributions (terminate the entire contribution);
- Prepay the total contribution for the FMLA leave period (employee's contribution);
- Choose the pay-as-you-go method. If the employee chooses this method of payment, the employee's contribution is due at the same time the contribution would be made by payroll deduction. Employees who fail to pay timely will be granted a thirty (30) day grace period to pay the contributions. Employees who fail to pay the required amount by the end of the thirty (30) day grace period, will have the medical expense flexible spending account automatically terminated back to the last date through which contributions were paid. The employee will not be able to participate the remainder of the year.

  When the employee is on FMLA leave, forward contribution checks to:

  Personnel Cabinet
  Department for Employee Insurance
  Commonwealth Choice Administrator
  200 Fair Oaks, Suite 501
  Frankfort, Kentucky 40601

**2. Returning from FMLA Leave**

Upon the employee's return from FMLA leave, the employee must be reinstated to the prior elections before FMLA leave unless there has been a status change (birth, adoption, etc), in which case, the employee is held to the thirty (30) day rule for requesting the change.

The employee may choose one of the following:

- Proration: Employee may elect to continue the same monthly contribution as prior to the FMLA leave and the annual amount is reduced by the contributions missed; or
- Reinstatement: Employee may elect to make-up the missed contributions.

**NOTE:** If employees choose suspension of their health care FSA or fail to pay the past-due contributions, the agency is to request a refund of the employer contribution for the applicable pay period.

**3. Not returning from FMLA Leave**

When employees have exhausted their FMLA leave, and do not return to work (begins LWOP), the insurance coordinator must notify the employee of their COBRA rights, regardless of the employee's health care FSA status during the FMLA.

For purposes of COBRA, the date of the COBRA Qualifying Event is the date the FMLA leave ends. The employee is eligible for eighteen (18) months of COBRA.

## C. Military Leave

Employees may discontinue their contributions to the Commonwealth Choice Program when they are activated with the armed services. This option will allow the employee to be reinstated when returning to employment from military leave. The employee may select one of the following upon return:

- **Proration:** employee may elect to continue at the same monthly contribution prior to military leave and the annual amount is reduced by the contributions missed; or
- **Reinstatement:** employee may elect to makeup the missed contributions.

Employees returning between the first (1st) and the fifteenth (15th) of the month will need to pay the entire employee's contribution and the agency will be required to pay the employer's portion of the contribution, if any, for the health care FSA for the month the employee returns.

Employees returning on or after the 16th of the month will only need to pay half of their contribution and the agency will be required to pay the employer's portion of the contribution, if any, for the month returned.

# VI HIPAA

Employees, as well as their eligible dependents, enrolled in the health care FSA must be provided with a written certificate of prior creditable coverage, in accordance with the Health Insurance Portability and Accountability Act (HIPAA), if they terminate employment or retire while actively participating in the program. The HIPAA certificate must be furnished even if all or part of the contribution was from the employer. A copy of the HIPAA certificate will be provided to employees and eligible dependents, from the TPA, upon leaving employment.

# VII Commonwealth Choice Contacts

## A. Plan administrator

Humana Spending Account Administration
PO Box 19068
Green Bay, WI 54307

Customer Service:
(800) 604-6228
(920) 632-9200 (FAX)

## B. Paper reimbursement requests

If an employee does not use the HumanaAccess card to pay for out of pocket expenses, they may fax or mail paper claims for reimbursement of expenses incurred to the above fax number or address, respectively.

## C. DEI FSA Team

An employee having questions regarding eligibility for the Commonwealth Choice Flexible Spending Accounts may contact:

Personnel Cabinet
Department for Employee Insurance
Flexible Spending Account Team
200 Fair Oaks Lane, Suite 501
Frankfort, KY 40601

(502) 564-0350
(502) 564-0351
(502) 564-0364 (FAX)

# Glossary of Terms

**Change in Status** – Any event that changes the following:

(a) legal marital status (marriage, death of spouse, divorce, legal separation or annulment);
(b) number of dependents of qualifying individuals (for Dependent Care Assistance only), (birth, adoption, placement for adoption, or death of a dependent child);
(c) employment status (commencement or termination of work; strike or lockout; commencement or return from an unpaid leave of absence; or any benefit eligibility condition that depends on employment status, whereby an employment status change would result in an individual either becoming, or ceasing to be, eligible under a plan for Employee, Spouse or Dependent);
(d) dependent status (employee's dependent child satisfies, or ceases to satisfy, coverage requirements due to attainment of age, student status or any similar circumstances);
(e) residence or work site (change in Employee's, Spouse's or Dependent's place of residence or employment); and
(f) such other events as may be permitted by law or regulation.

**COBRA** – The Consolidated Omnibus Budget Reconciliation Acts of 1986, as amended, including parallel provisions as outlined in Title XXII of the Public Health Service Act. COBRA allows an employee to continue their group health insurance coverage for a period of time.

**Contract Year** – The year commencing on January 1 and ending on December 31 of each year. For the purposes of this Administration Manual, the terms "contract year" and plan year" are interchangeable.

**Couple Coverage** – Coverage for the member and their eligible covered spouse.

**Coverage Level** – Single, parent plus, couple or family coverage.

**Creditable Coverage** - Prior coverage by a covered person under any of the following:
(A) a group health plan, including church and governmental plans;
(B) health insurance coverage;
(C) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
(D) Medicaid, other than coverage consisting solely of benefits under section 1928 of the Social Security Act;
(E) the health plan for active and certain former military personnel, including CHAMPUS and TRICARE;
(F) the Indian Health Service or other tribal organization program;
(G) a state health benefits risk pool;
(H) the Federal Employees Health Benefits Program;
(I) a public health plan as defined in federal regulations;
(J) a health benefit plan under section 5(e) of the Peace Corps Act; and any other plan which provides comprehensive hospital, medical, and surgical services and meets federal requirements.

Creditable coverage does not include any of the following:

- accident only coverage, disability income insurance, or any combination thereof;
- supplemental coverage to liability insurance;
- liability insurance, including general liability insurance and automobile liability insurance;
- workers' compensation or similar insurance;
- automobile medical payment insurance;
- credit-only insurance;
- coverage for on-site medical clinics;
- benefits if offered separately:
  (1) limited scope dental and vision;
  (2) long-term care, nursing home care, home health care, community based care, or any combination thereof; and
  (3) other similar, limited benefits.
- benefits if offered as independent, non-coordinated benefits:
  (1) specified disease or illness coverage; and
  (2) hospital indemnity or other fixed indemnity insurance.
- benefits if offered as a separate policy:
  (1) Medicare Supplement insurance;
  (2) supplemental coverage to the health plan for active and certain former military personnel, including CHAMPUS and TRICARE; and
  (3) similar supplemental coverage provided to group health plan coverage.

**Cross-Reference** – A husband and wife who, as eligible employees of the KEHP, may elect to have both state paid contributions applied to their family coverage.

**Dual Employment** – Any employee who works full-time for different agencies (i.e. school board and state agency) and meets the eligibility requirement for both employers.

**Effective Date** – The date on which coverage for a covered person begins.

**Eligible Person** – A person who meets the eligibility requirements of the KEHP.

**Employee** – A person who is employed by agencies of the KEHP and eligible to apply for coverage under a KEHP.

**Family Coverage** – Coverage for the member, the member's spouse under a legally valid existing marriage and one or more dependent children.

**Kentucky Employees Health Plan (KEHP)** – The group, which is composed of eligible employees of state agencies, boards of education, health departments, quasi agencies, retirees of KCTCS, retirees of the Kentucky Retirement Systems, Teachers' Retirement System, the Legislators Retirement Plan and the Judicial Retirement Plan who are under age 65, and their eligible dependents.

**Late Enrollee** – An eligible person who requests enrollment in a plan after the initial open enrollment period. An individual shall not be considered a late enrollee if:

(a) The person enrolls during their initial enrollment period;
(b) The person enrolls during any annual open enrollment period; or
(c) The person enrolls during a special enrollment period.

**Member** – An employee, retiree or COBRA participant who is covered by one of the health plans offered by the KEHP.

**Open Enrollment** – a defined period of time, prior to the beginning of a Coverage Period during which an employee shall be entitled to elect benefit options for the subsequent coverage period.

**Parent Plus** – Coverage for the member and eligible dependents, except the spouse.

**Plan Year** – Each successive twelve-month period starting on January 1 and ending on December 31.

**Premium** – The periodic charges due which the member, or the member's group, must pay to maintain coverage.

**Premium Due Date** – The date on which a premium is due to maintain coverage under the KEHP.

**Qualified Beneficiary** – Any individual who, on the day before a COBRA Qualifying Event, is covered under the Plan by virtue of being on that day a covered person, or any child who is born or placed for adoption with a member during a period of COBRA continuation coverage.

**Qualifying Event** – A specific situation or occurrence that enables an eligible person to enroll or disenroll outside the designated enrollment period as a result of that person becoming eligible for or losing eligibility for coverage under this Plan or another plan.

**Retiree** – A member of a retirement plan administered by the Kentucky Retirement Systems, Kentucky Teachers' Retirement System, Legislators Retirement Plan, Judicial Retirement Plan or any other state retirement system, who is under age 65.

**Single Coverage** – Coverage for the member only.

**Special Enrollment Period** – A period of time during which an eligible person or dependent who loses other health insurance coverage or incurs a change in status may enroll in the plan without being considered a late enrollee.

**SAMPLE**
**USE YOUR AGENCY LETTERHEAD**

**M E M O R A N D U M**

TO: *(Employee)*

FROM: Insurance Coordinator

DATE:

SUBJECT: TEFRA for Active Employees Age 65 and Over

This letter is to inform an employee, nearing the age of 65, of his/her health insurance options upon becoming eligible for Medicare. As a result of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Medicare now supplements employer group health insurance plans. This means that if an employee elects coverage under the state sponsored health insurance plan, Medicare will pay benefits on a secondary basis.

**MEDICARE**

**You will receive information regarding Medicare enrollment approximately three months prior to your 65th birthday**. *If you are eligible* for Medicare Part A, the coverage will be free and enrollment will be automatic. Medicare Part B is **not** free and enrollment is **not** automatic. You are encouraged to contact your local Social Security office to determine your eligibility for these programs.

**KENTUCKY EMPLOYEES HEALTH PLAN (KEHP)**

Your Medicare eligibility or enrollment (Part A & Part B) does not affect your eligibility to continue coverage with the KEHP as long as you continue to meet the eligibility requirements as an employee. State sponsored plans offer the same health care coverage (under like conditions) to all active employees, regardless of age.

**EMPLOYEE OPTIONS**

Since you will be eligible to participate in Medicare and the KEHP, you should compare the cost of each, the benefits of each and make your decisions based upon your needs.

You may choose Medicare Parts A & B as your only source of coverage and waive your state sponsored health insurance. There is a monthly premium for Medicare Part B.

You may choose not to enroll in Medicare Part B and continue in the KEHP. The health insurance carrier will coordinate benefits with Medicare. You may delay enrollment in Medicare Part B until a later date, however, you will need to contact your local Social Security office regarding the Special Enrollment requirements, including dates.

Contact your local Social Security office or check the Centers for Medicare/Medicaid Services website* to obtain all the information necessary to make your decisions.

*http://cms.hhs.gov/default.asp?fromhcfadotgov=true

**M E M O R A N D U M**

TO: New Employees or Prospective Health Insurance Enrollees

FROM: (Name of State Agency, Board of Education, Local Health Department, KCTCS, etc.)

DATE:

**NOTICE ABOUT SPECIAL ENROLLMENT RIGHTS**

If you are declining enrollment for you, your spouse and/or any of your eligible dependents because of other health insurance coverage, you may be able to make a mid-year change in the Kentucky Employees Health Plan (KEHP) if you/they lose the other health coverage. If other health coverage is lost, you must request enrollment in the KEHP no later than thirty (30) days of the loss.

In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or the placement for adoption, you may be able to enroll yourself, your spouse, and/or your dependents in the KEHP, provided that you request enrollment within thirty (30) days of the date of the event. You will have sixty (60) days from the date of birth to add newborns or newly adopted or placed children. However, if you choose to add other eligible dependents at that time, the change must be made no later than thirty (30) days.

**NOTICE ABOUT WOMEN'S HEALTH AND CANCER RIGHTS ACT**

The Women's Health and Cancer Rights Act requires the Commonwealth to notify you, as a participant in the KEHP, of your rights related to benefits provided through the program in connection with a mastectomy. You have rights to coverage provided in a manner determined in consultation with your attending physician for:

(1) all stages of reconstruction of the affected breast ;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
(3) prostheses and treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the Plan's regular deductible, if any, and applicable co-payment or co-insurance amounts, depending upon the plan type and coverage option you have selected. For further details, please refer to your Summary Plan Description.

**Keep this notice for your records.**

# Health Insurance Checklist For New Employees

| **Name**<br><br>LAST FIRST MI | | | **Social Security Number** |
|---|---|---|---|
| **Hire Date** | **Company Name** | **Company Number** | **Work Phone**<br><br>( ) |

Following is a list of your rights and responsibilities regarding the Kentucky Employees Health Plan (KEHP). Read this form carefully and make sure you understand each item. You may direct your questions to _____ (your insurance coordinator) or to the Department for Employee Insurance at 502-564-6534 or 888-581-8834.

As a new employee I understand:

☐ that I have thirty (30) calendar days from my date of employment to enroll in one of the available health insurance plans. The thirty (30) days are counted beginning with the day after my hire date. If I am an employee of an agency that has a different probationary period, I must sign and date my application no later than thirty (30) days prior to my coverage effective date.

☐ that I must submit all applications for health insurance (including if I waive coverage) and Flexible Spending Accounts to my agency's insurance coordinator. The forms must be signed and dated by the above date.

☐ that I will be subject to a one time twelve (12) month waiting period for pre-existing conditions unless I have had prior creditable coverage for at least twelve (12) months and there has been no more than a sixty-three (63) consecutive day break in coverage between the termination of that coverage and the effective date of my coverage with the KEHP. Any prior period of coverage that is less than twelve (12) months can be applied against the pre-existing condition waiting period.

☐ that I must indicate my level of coverage on my application.

- Single – employee only
- Parent Plus – employee and dependent child(ren)
- Couple – employee and spouse
- Family – employee, spouse, and dependent child(ren)

☐ that if I meet all requirements and elect to start a cross-reference payment option with my spouse, who is an existing employee of the KEHP, and one of us terminates employment, the remaining employee will be responsible for the payment of the full family premium.

☐ that if I fail to enroll within the specified deadline, I will be set up as a waiver with no Flexible Spending Account. I will only be able to enroll in the KEHP if a Qualifying Event takes place that would allow me to enroll or during an Open Enrollment period.

☐ that every year there is a defined Open Enrollment period for health insurance that provides me the opportunity to make any type of change in my health insurance coverage and Flexible Spending Account Program, if applicable.

Note: Children covered by court order or administrative order may not be dropped from my insurance coverage except by a subsequent court order or administrative order.

☐ that outside of the annual Open Enrollment period I will only be allowed to make changes to my current plan and, in appropriate circumstances, change plans within thirty (30) days of a Qualifying Event or up to sixty (60) days for newborns (see the Health Insurance Handbook for more information on adding newborns and when they will be effective). A list of Qualifying Events is available from your insurance coordinator or the Personnel Cabinet's Web site.

☐ that it is my responsibility to contact my agency's insurance coordinator no later than thirty (30) days of any event that may affect my coverage.

☐ that the Commonwealth offers a Premium Conversion program that allows me to pay my portion of the health insurance premium with pre-tax dollars. I understand that I will be automatically enrolled in the program by virtue of enrolling in health insurance, unless I sign a cancellation form.

☐ that my coverage will begin no earlier than on the first day of the second month following my employment or on the date stipulated by my employer.

☐ that if I experience a COBRA Qualifying Event, such as termination of employment that causes loss of coverage, I have the right to continue my health insurance at my own expense under COBRA.

☐ that if I decide that I do not want coverage at this time, I can waive (decline) coverage by completing the appropriate sections of the application. If I waive coverage because I am covered under my spouse's plan, I will be allowed to enroll in a plan through the KEHP if one of the following occurs:

1. my spouse's employer group health insurance terminates;
2. loss of eligibility;
3. the spouse's employer ceases contributing to the plan;
4. if COBRA coverage is involved, the COBRA coverage expires;
5. loss of a health insurance policy.

**Check with your spouse's health plan before waiving coverage. Some employers will not cover you if you are eligible for health benefits through your own employer.**

☐ that I may have the opportunity to enroll in the Flexible Spending Account (FSA) program, if applicable, no later than thirty (30) days of my date of employment. I have obtained the appropriate FSA information and application from my insurance coordinator.

___ that I may contribute my own money into either the Health Care or Dependent Care FSA. Once I have directed money into the Health Care FSA, changes are permitted for a HIPAA Special Enrollment Right or a Change in Status (Qualifying Event) if the change is requested no later than thirty (30) days of the event giving rise to that right or change. Changes are allowed to the Dependent Care FSA with an approved Change in Status.

No Qualifying Event allows members to stop health insurance in order to enroll in a FSA.

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

☐ Have you worked for any other agency participating in the KEHP within the last thirty (30) days?

Yes ☐ No ☐

If yes, please give name of agency and date terminated or transferred.

_____ _____/_____/_____

Agency Termination or Transfer Date

☐ Are you retired from a state-sponsored retirement system?

Yes ☐ No ☐

If yes, please specify which system:

_____ Judicial Retirement Plan
_____ Legislators Retirement Plan
_____ KCTCS
_____ Kentucky Retirement Systems
_____ Kentucky Teachers' Retirement System

I acknowledge that I have received copies of the following:

☐ Health Insurance Handbook (includes the Health Insurance Application)

☐ Flexible Spending Account Information, if applicable

☐ Memorandum regarding Notice of Special Enrollment Rights and Women's Health and Cancer Rights Act (refer to Appendix B)

☐ Other _____

**I certify that I have had my health insurance and Flexible Spending Account benefits explained and that I understand the benefits and my responsibilities.**

_____ _____ _____

Employee Signature Date Agency Representative

*Employee should keep the original notice for his/her records.*

*Insurance coordinator should keep a copy in the employee's file.*
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

# SAMPLE

**USE YOUR AGENCY LETTERHEAD**

**M E M O R A N D U M**

TO: *(Employee on LWOP)*

FROM: *(Insurance Coordinator)*

DATE:

SUBJECT: Guidelines for Benefits While on Approved LWOP

As an employee on Leave Without Pay (LWOP), you are eligible to continue your health insurance, Commonwealth Choice contribution, and any miscellaneous insurance(s) that you are having payroll deducted at your own expense if you lose your coverage under the Plan. You must contact *(Insurance Coordinator)* to make arrangements to continue your benefits coverage.

**Health Insurance**

To continue your group health insurance coverage you must pay the premiums to your agency or through COBRA. After you have been on LWOP for 30 or more working days and if you lose coverage under the Plan, you will receive a COBRA Notification Letter.

A. If you are on LWOP and you have pay during the month the leave starts, you will be eligible for the employer contribution for health insurance for the following month. However, if the pay you receive is not sufficient to cover the employee's portion of the premium, you will need to submit a check for the amount due.

   If you are on leave without pay and you do not have pay during a month, you will not be eligible for the employer contribution for health insurance for the following month. In this case, you must pay the total premium amount (employer and employee portion, if applicable) to continue your health insurance coverage.

   Any portion of a premium due by you must be submitted to the insurance coordinator by the 20th of the month. The check must be payable to the Kentucky State Treasurer and have your Social Security Number listed on the check. The insurance coordinator will forward the payment to the DEI.

   **NOTE**: If you fail to submit appropriate premium payments due within the specified deadline, the Plan may cancel the ENTIRE POLICY.

B. If you will be on LWOP for 30 or more days, you may continue your coverage through COBRA if you lose coverage under the Plan. You will need to fill out the COBRA election form and submit it, with your payment, to Ceridian. Follow the instructions provided with your COBRA materials.

**Health Care Flexible Spending Account**

If you are eligible and you decide to continue your participation in the Health Care FSA, you must submit a check to your insurance coordinator, in the amount of $_____ made payable to the Kentucky State Treasurer**.** If you do not continue this contribution while on LWOP, you will **not** be eligible to participate in the program for the remainder of the plan year once you return to work.

**Miscellaneous Insurances (payroll deducted)**

To continue your miscellaneous insurances that you are having payroll deducted, send payments directly to the insuring company. Our records indicate that you have the following additional insurance and/or deductions:

*(List payroll deductions)*

When you return to work after being on LWOP you must work at least one day in the month you return to be eligible to receive the employer contribution for health insurance for the following month. If you do not work one or more days in the month you return, the first day of the second month rule applies regarding your effective date of your health insurance.

When you return from LWOP your length of absence may affect your health insurance. If you do not elect to continue health insurance while on LWOP, and have more than a 63 day break in coverage, you will be subject to pre-existing conditions when your coverage resumes.

When you return to work after being on LWOP you will not be eligible to make any changes to the health insurance coverage in which you were enrolled prior to the LWOP unless one of the following has occurred:

- You experience a Qualifying Event and you apply for an appropriate change within thirty (30) days of returning to work, except when adding a child ONLY due to birth, adoption, or placement for adoption, which would require you to apply within sixty (60) days.

- You return in a new plan year or after missing the Open Enrollment period and you apply for a coverage change no later than thirty (30) days after your return.

- The coverage in which you were enrolled prior to the beginning of the LWOP is not available upon your return. You will have no more than thirty (30) days after your return to apply for an appropriate change.

The insurance coordinator must provide the necessary applications upon return.

Should you have any questions, you may contact me at _____.

# SAMPLE

**USE YOUR AGENCY LETTERHEAD**

**MEMORANDUM**

TO: *(Employee on Family Leave)*

FROM: *(Insurance Coordinator)*

DATE:

SUBJECT: Guidelines for Benefits While on Approved Family Leave

This letter is to inform you of your health insurance responsibilities as an employee on family leave. As an employee on Family Leave, the state will continue to make the employer contributions for your health insurance or Commonwealth Choice (Flexible Spending Account), if applicable. It is your responsibility to make timely payments of any employee contribution amounts that had previously been deducted for health insurance or for Commonwealth Choice.

**Health Insurance**

While on family leave, two conditions must be met in order to qualify for the employer contribution for health insurance. The first is you must maintain the level of coverage that was in effect before going on leave. Secondly, you must pay the employee contribution, if applicable. To continue your health insurance you must submit a check made payable to the Kentucky State Treasurer, in the amount of $_____ (employee contribution).

**Commonwealth Choice *(if applicable)***

If you are enrolled in Commonwealth Choice and contribute your own money (employee contribution), you may submit a check in the amount of $_____ made payable to the Kentucky State Treasurer. If you choose not to continue the employee contribution, the annual contribution amount will be adjusted accordingly. If you wish to resume your employee contribution when you return from family leave, you must complete a new enrollment form.

The payments for health insurance and Commonwealth Choice should be submitted to the following address by the 10th of each month. Please include your Social Security Number on each check.

_____

_____

_____

**Miscellaneous Insurances (payroll deducted)**

All other insurances and deductions made from your paycheck will cease unless timely payments are made. You should contact the company directly. Our records indicate that you have the following additional insurance and/or deductions:

*(List payroll deductions)*

If you exhaust your family leave time before you are able to return to work and you are eligible, you will be sent a COBRA notification letter, which allows you to continue your health insurance totally at your own expense. Should you opt not to continue under COBRA, you will be restored to your previous level of coverage immediately upon your return to work.

If you have any questions, please feel free to contact me at _____.

# Personnel Cabinet
# Department for Employee Insurance

## 2006 Health Insurance Total Monthly Premiums

| | Single | Parent Plus | Couple | Family |
|---|---|---|---|---|
| Commonwealth Essential | Not Offered | $614.11 | $921.16 | $1,023.51 |
| Commonwealth Enhanced | $488.96 | $733.44 | $1,100.16 | $1,222.40 |
| Commonwealth Premier | $503.66 | $755.48 | $1,133.23 | $1,259.14 |

## 2006 Monthly Employee Contributions -- Non-Smoker

| | Single | Parent Plus | Couple | Family | Family Cross-Reference |
|---|---|---|---|---|---|
| Commonwealth Essential | Not offered | $55.00 | $259.52 | $320.14 | $0 |
| Commonwealth Enhanced | $0.00 | $114.00 | $357.72 | $429.24 | $9.72* |
| Commonwealth Premier | $18.20 | $170.38 | $398.66 | $474.74 | $33.08* |

*Contribution is per employee

## 2006 Monthly Employee Contributions -- Smoker

| | Single | Parent Plus | Couple | Family | Family Cross-Reference |
|---|---|---|---|---|---|
| Commonwealth Essential | Not offered | $85.00 | $289.52 | $350.14 | $15.00* |
| Commonwealth Enhanced | $15.00 | $144.00 | $387.72 | $459.24 | $24.72* |
| Commonwealth Premier | $33.20 | $200.38 | $428.66 | $504.74 | $48.08* |

*Contribution is per employee

# 2006 COBRA Rates

| | Single | Parent Plus | Couple | Family |
|---|---|---|---|---|
| Commonwealth Essential | Not Offered | $626.39 | $939.58 | $1,043.98 |
| Commonwealth Enhanced | $498.74 | $748.10 | $1,122.16 | $1,246.85 |
| Commonwealth Premier | $513.73 | $770.59 | $1,155.89 | $1,284.32 |

# 2006 COBRA Calendar

| QUALIFYING EVENT DATE | 18 MONTHS | 36 MONTHS |
|---|---|---|
| 12/05 | 06/30/2007 | 12/31/2008 |
| 01/06 | 07/31/2007 | 01/31/2009 |
| 02/06 | 08/31/2007 | 02/28/2009 |
| 03/06 | 09/30/2007 | 03/31/2009 |
| 04/06 | 10/31/2007 | 04/30/2009 |
| 05/06 | 11/30/2007 | 05/31/2009 |
| 06/06 | 12/31/2007 | 06/30/2009 |
| 07/06 | 01/31/2008 | 07/31/2009 |
| 08/06 | 02/28/2008 | 08/31/2009 |
| 09/06 | 03/31/2008 | 09/30/2009 |
| 10/06 | 04/30/2008 | 10/31/2009 |
| 11/06 | 05/31/2008 | 11/30/2009 |
| 12/06 | 06/30/2008 | 12/31/2009 |

# County and Group Number Table

| FIPS | CO. NO. | COUNTY NAME | AREA | GROUP NO. |
|---|---|---|---|---|
| 001 | 001 | ADAIR | LEX | P6070 |
| 003 | 002 | ALLEN | LOU | P5941 |
| 005 | 003 | ANDERSON | LEX | P6070 |
| 007 | 004 | BALLARD | LOU | P5941 |
| 009 | 005 | BARREN | LOU | P5941 |
| 011 | 006 | BATH | LEX | P6070 |
| 013 | 007 | BELL | LEX | P6070 |
| 015 | 008 | BOONE | N.KY | P6070 |
| 017 | 009 | BOURBON | LEX | P6070 |
| 019 | 010 | BOYD | LEX | P6070 |
| 021 | 011 | BOYLE | LEX | P6070 |
| 023 | 012 | BRACKEN | LEX | P6070 |
| 025 | 013 | BREATHITT | LEX | P6070 |
| 027 | 014 | BRECKINRIDGE | LOU | P5941 |
| 029 | 015 | BULLITT | LOU | P5941 |
| 031 | 016 | BUTLER | LOU | P5941 |
| 033 | 017 | CALDWELL | LOU | P5941 |
| 035 | 018 | CALLOWAY | LOU | P5941 |
| 037 | 019 | CAMPBELL | N.KY | P6070 |
| 039 | 020 | CARLISLE | LOU | P5941 |
| 041 | 021 | CARROLL | LOU | P5941 |
| 043 | 022 | CARTER | LEX | P6070 |
| 045 | 023 | CASEY | LEX | P6070 |
| 047 | 024 | CHRISTIAN | LOU | P5941 |
| 049 | 025 | CLARK | LEX | P6070 |
| 051 | 026 | CLAY | LEX | P6070 |
| 053 | 027 | CLINTON | LEX | P6070 |
| 055 | 028 | CRITTENDEN | LOU | P5941 |
| 057 | 029 | CUMBERLAND | LEX | P6070 |
| 059 | 030 | DAVIESS | LOU | P5941 |
| 061 | 031 | EDMONSON | LOU | P5941 |
| 063 | 032 | ELLIOTT | LEX | P6070 |
| 065 | 033 | ESTILL | LEX | P6070 |
| 067 | 034 | FAYETTE | LEX | P6070 |
| 069 | 035 | FLEMING | LEX | P6070 |
| 071 | 036 | FLOYD | LEX | P6070 |
| 073 | 037 | FRANKLIN | LEX | P6070 |
| 075 | 038 | FULTON | LOU | P5941 |
| 077 | 039 | GALLATIN | N.KY | P6070 |
| 079 | 040 | GARRARD | LEX | P6070 |
| 081 | 041 | GRANT | N.KY | P6070 |
| 083 | 042 | GRAVES | LOU | P5941 |
| 085 | 043 | GRAYSON | LOU | P5941 |
| 121 | 061 | KNOX | LEX | P6070 |
| 123 | 062 | LARUE | LOU | P5941 |
| 125 | 063 | LAUREL | LEX | P6070 |
| 127 | 064 | LAWRENCE | LEX | P6070 |
| 129 | 065 | LEE | LEX | P6070 |
| 131 | 066 | LESLIE | LEX | P6070 |
| 133 | 067 | LETCHER | LEX | P6070 |
| 135 | 068 | LEWIS | LEX | P6070 |
| 137 | 069 | LINCOLN | LEX | P6070 |
| 139 | 070 | LIVINGSTON | LOU | P5941 |
| 141 | 071 | LOGAN | LOU | P5941 |
| 143 | 072 | LYON | LOU | P5941 |
| 151 | 076 | MADISON | LEX | P6070 |
| 153 | 077 | MAGOFFIN | LEX | P6070 |
| 155 | 078 | MARION | LOU | P5941 |
| 157 | 079 | MARSHALL | LOU | P5941 |
| 159 | 080 | MARTIN | LEX | P6070 |
| 161 | 081 | MASON | LEX | P6070 |
| 145 | 073 | MCCRACKEN | LOU | P5941 |
| 147 | 074 | MCCREARY | LEX | P6070 |
| 149 | 075 | MCLEAN | LOU | P5941 |
| 163 | 082 | MEADE | LOU | P5941 |
| 165 | 083 | MEIFEE | LEX | P6070 |
| 167 | 084 | MERCER | LEX | P6070 |
| 169 | 085 | METCALFE | LOU | P5941 |
| 171 | 086 | MONROE | LOU | P5941 |
| 173 | 087 | MONTGOMERY | LEX | P6070 |
| 175 | 088 | MORGAN | LEX | P6070 |
| 177 | 089 | MUHLENBURG | LOU | P5941 |
| 179 | 090 | NELSON | LOU | P5941 |
| 181 | 091 | NICHOLAS | LEX | P6070 |
| 183 | 092 | OHIO | LOU | P5941 |
| 185 | 093 | OLDHAM | LOU | P5941 |
| 187 | 094 | OWEN | LEX | P6070 |
| 189 | 095 | OWSLEY | LEX | P6070 |
| 191 | 096 | PENDLETON | N.KY | P6070 |
| 193 | 097 | PERRY | LEX | P6070 |
| 195 | 098 | PIKE | LEX | P6070 |
| 197 | 099 | POWELL | LEX | P6070 |
| 199 | 100 | PULASKI | LEX | P6070 |
| 201 | 101 | ROBERTSON | LEX | P6070 |
| 203 | 102 | ROCKCASTLE | LEX | P6070 |
| 205 | 103 | ROWAN | LEX | P6070 |

| FIPS | CO. NO. | COUNTY NAME | AREA | GROUP NO. |
|---|---|---|---|---|
| 087 | 044 | GREEN | LOU | P5941 |
| 089 | 045 | GREENUP | LEX | P6070 |
| 091 | 046 | HANDCOCK | LOU | P5941 |
| 093 | 047 | HARDIN | LOU | P5941 |
| 095 | 048 | HARLAN | LEX | P6070 |
| 097 | 049 | HARRISON | LEX | P6070 |
| 099 | 050 | HART | LOU | P5941 |
| 101 | 051 | HENDERSON | LOU | P5941 |
| 103 | 052 | HENRY | LOU | P5941 |
| 105 | 053 | HICKMAN | LOU | P5941 |
| 107 | 054 | HOPKINS | LOU | P5941 |
| 109 | 055 | JACKSON | LEX | P6070 |
| 111 | 056 | JEFFERSON | LOU | P5941 |
| 113 | 057 | JESSAMINE | LEX | P6070 |
| 115 | 058 | JOHNSON | LEX | P6070 |
| 117 | 059 | KENTON | N.KY | P6070 |
| 119 | 060 | KNOTT | LEX | P6070 |
| 207 | 104 | RUSSELL | LEX | P6070 |
| 209 | 105 | SCOTT | LEX | P6070 |
| 211 | 106 | SHELBY | LOU | P5941 |
| 213 | 107 | SIMPSON | LOU | P5941 |
| 215 | 108 | SPENCER | LOU | P5941 |
| 217 | 109 | TAYLOR | LOU | P5941 |
| 219 | 110 | TODD | LOU | P5941 |
| 221 | 111 | TRIGG | LOU | P5941 |
| 223 | 112 | TRIMBLE | LOU | P5941 |
| 225 | 113 | UNION | LOU | P5941 |
| 227 | 114 | WARREN | LOU | P5941 |
| 229 | 115 | WASHINGTON | LOU | P5941 |
| 231 | 116 | WAYNE | LEX | P6070 |
| 233 | 117 | WEBSTER | LOU | P5941 |
| 235 | 118 | WHITLEY | LEX | P6070 |
| 237 | 119 | WOLFE | LEX | P6070 |
| 239 | 120 | WOODFORD | LEX | P6070 |

# 2006 Humana Carrier Codes

| | Group # | Group # | Group # |
|---|---|---|---|
| | **P5941** | **P6070** | **P6077** |
| | Louisville Area | Lexington Area | No.Ky/Cinci Area |
| Commonwealth Essential | **CHLJ** | **CHMM** | **CHNP** |
| Commonwealth Enhanced | **CHL9** | **CHNC** | **CHOF** |
| Commonwealth Premier | **CHLW** | **CHMZ** | **CHN2** |